

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7292

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07222

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROHRERSVILLE MD.</u>		c. LENGTH OF STAY IN 1b <u>54 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X ROHRERSVILLE MD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST.</u>				d. STREET ADDRESS <u>1 MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM - DAVID - ALBIN</u>				4. DATE OF DEATH Month Day Year <u>JUNE - 25 - 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>FEBRUARY - 6 - 1877</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min <u>4 19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PRINCIPLE OF PUBLIC SCHOOL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MIDVALE PENN.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN W. ALBIN</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH STEPHEV</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>219-20-4726</u>		17. INFORMANT <u>MRS. CHARLOTTE ALBIN ROHRERSVILLE MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>3yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 3, 1958</u> to <u>June 25, 1958</u> , that I last saw the deceased alive on <u>June 25, 1959</u> , and that death occurred at <u>3:15</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. L. Van</u>				ADDRESS (Street, city or town, state) <u>Boonsboro</u>		DATE SIGNED <u>6/26/59</u>	
PHYSICIAN'S NAME (Type) <u>G. W. L. Van</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE - 27 - 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Bass</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR <u>JUN 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hearn</u>			

CERTIFICATE OF DEATH

WILLIAM
J. CONNOR
BOSTON

1919

Name of deceased		WILLIAM J. CONNOR	
Age		35	
Sex		Male	
Race		White	
Date of death		April 10, 1919	
Place of death		Boston, Mass.	
Cause of death		Tuberculosis of lungs	
Occupation		Clerk	
Signature of physician		[Signature]	
Signature of registrar		[Signature]	
Signature of informant		[Signature]	
Date of registration		April 15, 1919	
Place of registration		Boston, Mass.	

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7235

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07224

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>10 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X KEEDYSVILLE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				d. STREET ADDRESS <u>1 MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>A</u> <u>GRACE</u> <u>BAKER</u>				4. DATE OF DEATH Month Day Year <u>JUNE - 7 - 19 59</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY-21-1885</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>0</u> <u>16</u>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>KEEDYSVILLE WASH. CO. MD. U.S.A</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>BENJAMIN F. BAKER</u>				14. MOTHER'S MAIDEN NAME <u>EVA TAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ROBERT WYAND</u>		Address <u>KEEDYSVILLE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Megacolon</u> 350x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Enterocolitis</u> DUE TO (c) <u>Parkinsons -</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 weeks</u> <u>19 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 27</u> , 19 <u>59</u> , to <u>June 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 6</u> , 19 <u>59</u> , and that death occurred at <u>2:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. Helman</u> M.D.				ADDRESS (Street, city or town, state) <u>Boonsboro - Md.</u>		DATE SIGNED <u>6/8/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 10 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>KEEDYSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Coast</u>				ADDRESS <u>Boonsboro MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 11 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

CERTIFICATE OF DEATH

AMERICAN STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

282

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15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7234

CERTIFICATE OF DEATH

07223
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 years 9 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Convalescent Hospital		d. STREET ADDRESS 38 East Franklin Street	
3. NAME OF DECEASED (Type or print) First AMANDA Middle E. Last BAKER		4. DATE OF DEATH Month June Day 14 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 22, 1869
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Shippensburg, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua Mc Clure		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Isadora Mc Clure		Address East Greenwich, Conn.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse 450.0 DUE TO Arteriosclerosis - gen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) gen. (c)			INTERVAL BETWEEN ONSET AND DEATH none
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/14/59 , 19___, to 6/14/59 , 19___, that I last saw the deceased alive on 6/14/59 , 19___, and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis E. Shaw		DATE SIGNED 6/15/59	
PHYSICIAN'S NAME (Type) Louis E. Shaw		ADDRESS (Street, city or town, state) 119 E. Antietam Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/17/1959	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home		ADDRESS Hagerstown, Maryland	
24a. REC'D BY REGISTRAR JUN 18 '59		24b. REGISTRAR'S SIGNATURE Charles S. Thomas	

CERTIFICATE OF DEATH

WATKINS STATE DEPARTMENT OF HEALTH - ALABAMA

WATKINS STATE DEPARTMENT OF HEALTH - ALABAMA

2/28

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Usual Residence		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Report		Place of Report		County	
State		City		Zip	

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7236

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07225

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CORA Middle MAY Last BAKER		4. DATE OF DEATH Month June Day 11 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1900
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen work		10b. KIND OF BUSINESS OR INDUSTRY Mc Coys Ferry, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Patton		14. MOTHER'S MAIDEN NAME Minnie Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Donald Baker		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of ulcerative lesions of caecum (c) Carcinoma of caecum INTERVAL BETWEEN ONSET AND DEATH 24 hours 2 days 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Embolism; arteriosclerotic heart disease			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6 , 19 59 , to June 11 , 19 59 , that I last saw the deceased alive on June 11 , 19 59 , and that death occurred at 4:40 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John D. Turco		M.D. 302 W. Phoenix St	
PHYSICIAN'S NAME (Type) JOHN D TURCO		Hagerstown, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/1959	
22c. NAME OF CEMETERY OR CREMATORY River View Cemetery		22d. LOCATION (City, town, or county) (State) Hancock, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Sater - Rouzer Funeral Home H. Franklin Rager		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE JUN 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Date of birth</p>		<p>4. Place of birth</p>	
<p>5. Date of death</p>		<p>6. Place of death</p>	
<p>7. Cause of death</p>		<p>8. Manner of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>	
<p>11. Date of registration</p>		<p>12. Place of registration</p>	

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7293

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Washington</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Pa.</i> b. COUNTY <i>Fulton</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown Pa</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>McConnellsburg, Pa.</i>	
c. LENGTH OF STAY IN 1b. <i>5 weeks</i>		d. STREET ADDRESS <i>75X-31</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Gateway Conv. Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lydia</i> First Middle Last <i>Bard</i>		4. DATE OF DEATH <i>June 16, 1959</i> Month Day Year	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 19, 1868</i> 9. AGE (In years lost birthday) <i>90</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housekeeping</i>	11. BIRTHPLACE (State or foreign country) <i>Fulton Co, Pa.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Baltzer W. Melhoff</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth Hollinshead</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>George Bard, McConnellsburg, Pa.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chr. Endocarditis</i> <i>421.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterial Sclerosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i> <i>10 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 11, 1959</i> to <i>June 16, 1959</i> , that I last saw the deceased alive on <i>June 15, 1959</i> , and that death occurred at <i>10 A.</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>David R Brewer</i> M.D.		ADDRESS (Street, city or town, state) <i>Clear Spring Md</i> DATE SIGNED <i>6/19/59</i>	
PHYSICIAN'S NAME (Type) <i>David R Brewer</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>June 19, 59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Union</i>	22d. LOCATION (City, town, or county) (State) <i>Ayr Twp. Fulton, Pa.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. M. Lininger</i> ADDRESS <i>Mercersburg, Pa.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 8 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>

CERTIFICATE OF DEATH

1908

Place of death and burial

1908

1908

Return

Dr. J. H. Smith

May 11, 1908

David R. Brewer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7237

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07227

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 1/2 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Barnhart Last Barnhart		4. DATE OF DEATH Month 6 Day 4 Year 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26.1886
9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR Months 1 Days 10 IF UNDER 24 HRS. Hours 10 M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Labor	
11. BIRTHPLACE (State or foreign country) Fulton County Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Barnhart		14. MOTHER'S MAIDEN NAME Elizabeth Jordon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Webster Barnhart	
17. INFORMANT Webster Barnhart		Address Hancock Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis, right middle cerebral artery DUE TO (c) Hypertension cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH 12 hours 12 hours years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ASHD			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/4 , 19 59 , to 6/4 , 19 59 , that I last saw the deceased alive on 6/4 , 19 59 , and that death occurred at 9:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 145 S. Prospect St. DATE SIGNED 6/5/59			
ACTUAL SIGNATURE John C. Stauffer M.D.		PHYSICIAN'S NAME (Type) John C. Stauffer, M.D. Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6.7.59	22c. NAME OF CEMETERY OR CREMATORY Orchard Ridge Cemetery	22d. LOCATION (City, town, or county) (State) Near Hancock Washington Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard F. Shaw		24a. REC'D BY REGISTRAR DATE JUN 9 '59	
ADDRESS Hancock Md		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

7238

CERTIFICATE OF DEATH

07228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5½ months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Emma First Beard Last		4. DATE OF DEATH Month June 29, Day 19 Year 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1867
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Frederick Co., Md.	
11. BIRTHPLACE (State or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Mary Cline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hoy D. Newman, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) and general arteriosclerosis DUE TO (c) Cerebral thrombosis			INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia - lobar			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 14, 1959 , to June 29, 1959 , that I last saw the deceased alive on June 23, 1959 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 212 W. Washington St. Hagerstown, Maryland DATE SIGNED 6/30/59			
ACTUAL SIGNATURE Edward W. Ditto M.D.		PHYSICIAN'S NAME (Type) Edward W. Ditto 111 M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
burial		7-2-59	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Smithsburg, Cemetery		Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
24b. REGISTRAR'S SIGNATURE Clinton S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7239

CERTIFICATE OF DEATH

07229

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE Pa. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Blue Ridge Summit	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First C. Middle Baker Last Bernhart		4. DATE OF DEATH Month June 1, Day 19 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1892
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Department of Highway		10b. KIND OF BUSINESS OR INDUSTRY Lewisburg, Pa.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles H. Bernhart		14. MOTHER'S MAIDEN NAME Lena Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 183-12-8660A	
17. INFORMANT Mrs. Carolyn Bernhart, Blue Ridge Summit Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arteriosclerosis; Senile Maculatus		INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-10 , 19 59 , to 6-1 , 19 59 , that I last saw the deceased alive on 6-1 , 19 59 , and that death occurred at 1:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dalton M. Walty M.D.		ADDRESS (Street, city or town, state) 998 Potomac Ave. DATE SIGNED 6-2-59	
PHYSICIAN'S NAME (Type) DALTON M. Walty		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/4/59	22c. NAME OF CEMETERY OR CREMATORY Lewisburg	22d. LOCATION (City, town, or county) (State) Lewisburg, Union Co. Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Grove, Hagerstown Pa.		24a. REC'D BY REGISTRAR DATE JUN 4 '59	
24b. REGISTRAR'S SIGNATURE William L. Knecht			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7240

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07230
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 7 Wks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGARET Middle MYRTLE Last BLOOM				4. DATE OF DEATH Month June Day 10 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 23 1889	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Moats				14. MOTHER'S MAIDEN NAME Susan Fitch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Malton R. Bloom Hagerstown Md. R # 3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Left Hip & Left Clavicle 104.0 DUE TO: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic Heart Disease DUE TO: (c) Generalized Arterio-sclerotic							INTERVAL BETWEEN ONSET AND DEATH April 13-59
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralytic Agitation							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING () OR CONTRIBUTING () CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Yes at home - just slipped		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 10 Hour a. m. April 23 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Wash. Md.	(County)	(State)		
21. I certify that I attended the deceased from April 10, 1956 to June 10, 1959 , that I last saw the deceased alive on June 10, 1959 , and that death occurred at 6:50 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Sidney Novikstein M.D.				ADDRESS (Street, city or town, state) 1011-59			
DATE SIGNED 6-11-59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/59		22c. NAME OF CEMETERY OR CREMATORY Luthern Cemetery		22d. LOCATION (City, town, or county) (State) Bakersville Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR JUN 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Keane	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7294

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac River		d. STREET ADDRESS 24 W. Potomac Street	
3. NAME OF DECEASED (Type or print) First Harry Middle Franklin Last Bowman		4. DATE OF DEATH Month June Day 7 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3 1890
9. AGE (in years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months 8 Days 4 Hours Min 	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov.	11. BIRTHPLACE (State or foreign country) Lurray Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A		13. FATHER'S NAME Thomas Bowman	
14. MOTHER'S MAIDEN NAME Mary Putter		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 216 07 6991		17. INFORMANT Bertha Mae Bowman Address 24 W Potomac St. Williamsport Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation by drowning DUE TO Conditions, if any, which gave rise to immediate cause (b) 050.X (a), stating the underlying cause lost. (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Drowned when boat upset while fishing		20c. TIME OF INJURY Month, Day, Year June 3 19 59 Hour 3:50 P. M.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River	
20f. (City or town) Williamsport, (County) Wash (State) Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 8, 1959	
22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Williamsport, Md.		24a. REC'D BY REGISTRAR DAZ JUN 9 '59	
		24b. REGISTRAR'S SIGNATURE Charles S. Hanes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

7295

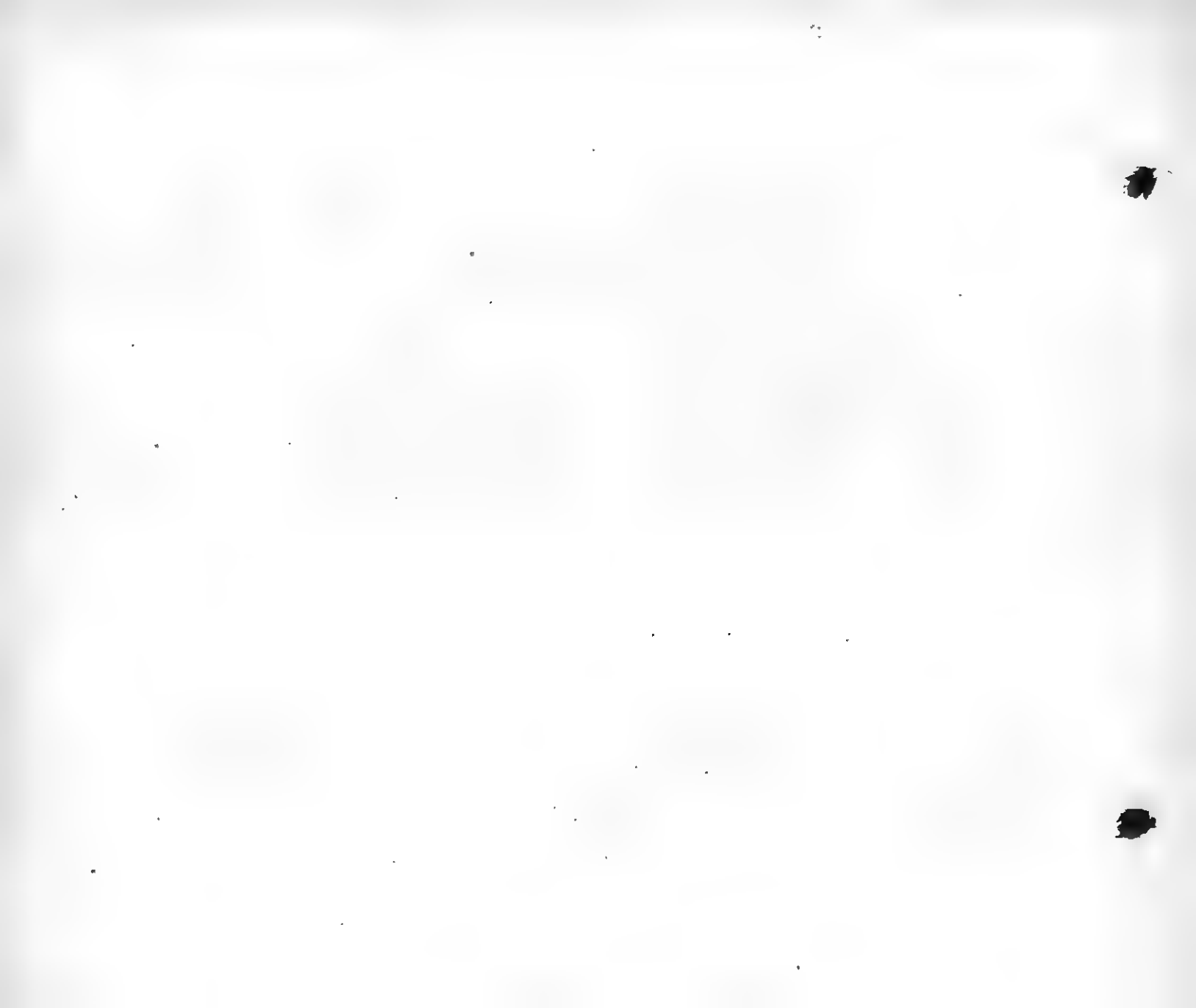
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 27 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		d. STREET ADDRESS 2425 Pennsylvania Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2425 Pennsylvania Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle MARY Last BREWBAKER		4. DATE OF DEATH Month June Day 13 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1874
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Franklin County, Penna.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph C. Miller	
14. MOTHER'S MAIDEN NAME Elizabeth Myers		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO None		INFORMANT Miss Laura Brewbaker 2425 Penna. Ave. Hagerstown, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Two years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Enter trochanteric fracture 1957		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 5, 1959 to June 13, 1959 , that I last saw the deceased alive on June 6, 1959 , and that death occurred at 9:15 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert V. H. Campbell M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 145 W Washington St 6/15/59	
PHYSICIAN'S NAME (Type) Robert V. H. Campbell		Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 16, 1959	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		ADDRESS Wm. G. Stoltz O-Phone.	
24a. REC'D BY REGISTRAR JUN 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7296

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07233

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, R #3</u>			c. LENGTH OF STAY IN 1b <u>24 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, R #3</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sharpsburg Pike</u>				d. STREET ADDRESS <u>Sharpsburg Pike</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Susan Ullum Brill</u>				4. DATE OF DEATH Month Day Year <u>June 28 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 21, 1867</u>		9. AGE (In years last birthday) <u>91 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Mineral 0th., W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John P. Ullum</u>				14. MOTHER'S MAIDEN NAME <u>Susan Ward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Lewis R. Brill, R. #3, Hagerstown, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Coronary Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>5 years</u> (c) <u>5 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-1-1959</u> to <u>6-28-1959</u> , that I last saw the deceased alive on <u>6-27-59</u> , 19 <u>59</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. W. Ditt</u>				ADDRESS (Street, city or town, state) <u>Hagerstown Md</u>		DATE SIGNED <u>6-29-59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditt</u>				M. D. <u>Hagerstown Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/30/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bakersville, Wash. Cty., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. K. Coffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaub</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7297

CERTIFICATE OF DEATH

07234

Reg. Dist. No. —

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK RURAL</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK - RURAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HAGERSTOWN MD. 121</u>				d. STREET ADDRESS <u>HAGERSTOWN MD. 121</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HUBERT WILLIAM BRINING</u>				4. DATE OF DEATH Month Day Year <u>JUNE 2 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 11 - 1892</u>	
9. AGE (In years last birthday) <u>66</u> yrs		10. AGE (In years last birthday) <u>66</u> yrs		11. BIRTHPLACE (State or foreign country) <u>MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER - NORMAN S. EARLEY - CONTRACTOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BEAVER CREEK WASH. CO. MD. U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM BRINING</u>				14. MOTHER'S MAIDEN NAME <u>KATIE RUDY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-09-3573</u>		17. INFORMANT <u>MRS. WILBOR SWOPE</u>		Address <u>HAGERSTOWN MD. 121</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardio vascular disease</u> DUE TO (c) <u>Tuberculosis-pulmonary</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>10-22-58</u> to <u>6-2-59</u> , 19 , that I last saw the deceased alive on <u>11-12-58</u> , 19 , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles F. Hess</u>				M.D. <u>Smithsburg, Md.</u>		DATE SIGNED <u>7-2-59</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE-4-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) <u>BEAVER CREEK WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Post</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 8 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles F. Hess</u>			

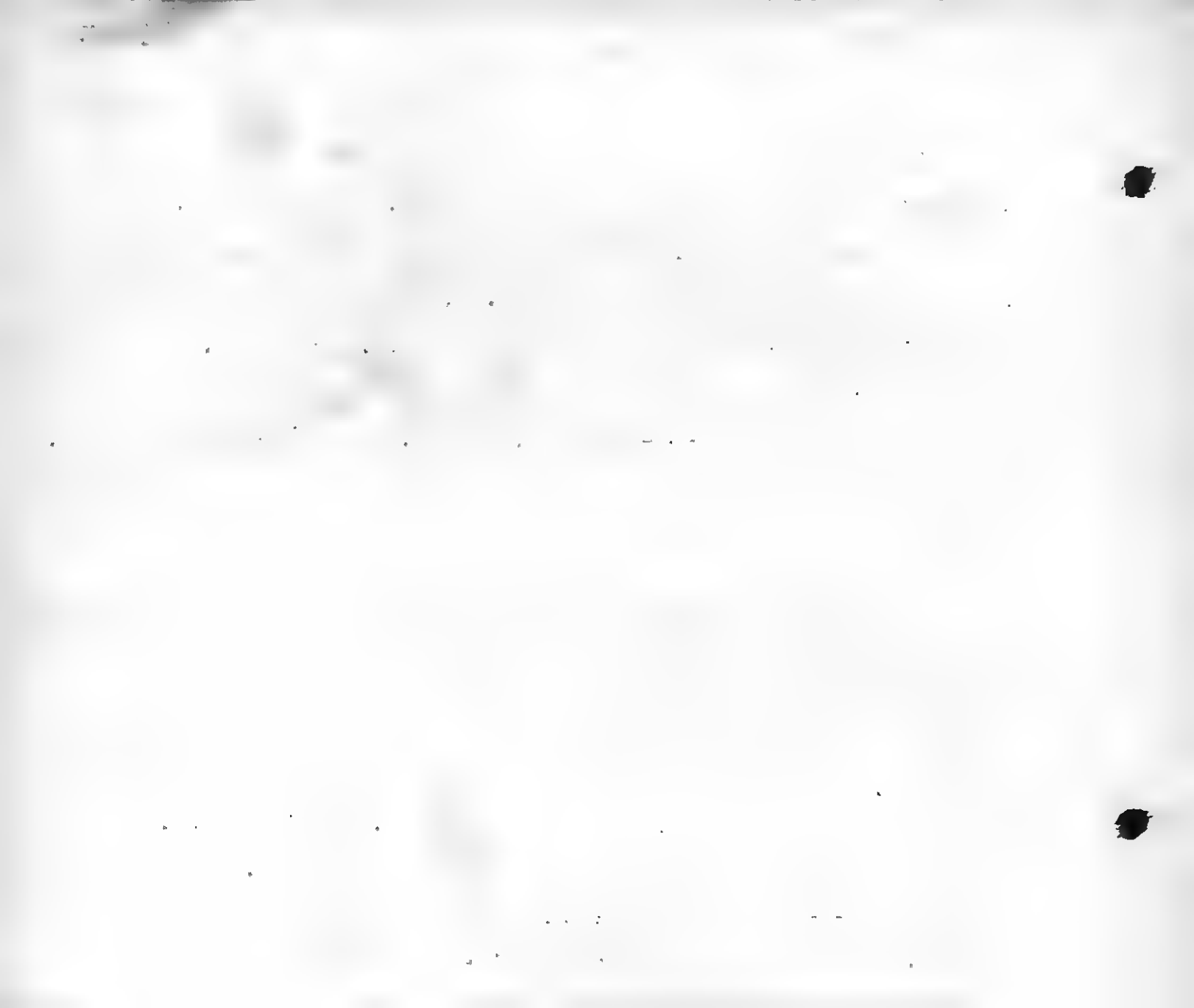
7241

CERTIFICATE OF DEATH

07235

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lewis Middle Garfield Last Charles				4. DATE OF DEATH Month June Day 29 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 6, 1881	
9. AGE (In years last birthday) 78 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drill Press Operator		11. BIRTHPLACE (State or foreign country) Near Clearspring Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Rudolph Charles				14. MOTHER'S MAIDEN NAME Mary Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 279-09-0835			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery Thrombosis DUE TO Arteriosclerosis Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Pancreatitis				INTERVAL BETWEEN ONSET AND DEATH 2 weeks unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 22, 1959 to June 29, 1959 that I last saw the deceased alive on June 28, 1959 , and that death occurred at 4 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 W. Washington St. DATE SIGNED ACTUAL SIGNATURE George Jennings M.D. PHYSICIAN'S NAME (Type) George Jennings Hagerstown Md.							
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-59		22c. NAME OF CEMETERY OR CREMATORY Ridge Hill Mem Park		22d. LOCATION (City, town, or county) (State) Lorain Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				24a. REC'D BY REGISTRAR DATE Jul 6 '59		24b. REGISTRAR'S SIGNATURE Carlton L. Kraw	



7242

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07236

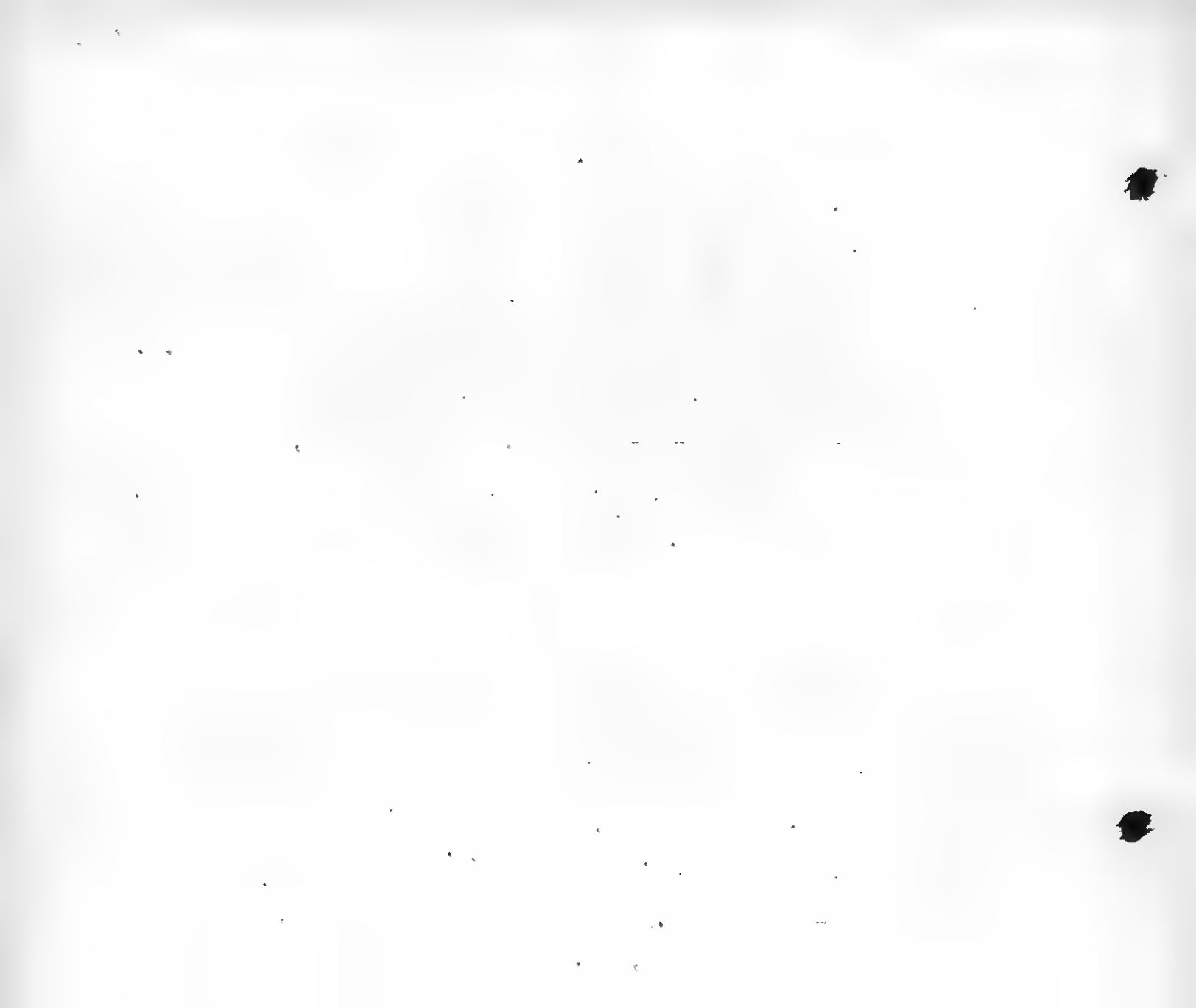
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN IB 3 wks.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Sykesville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. State Hospital		d. STREET ADDRESS Obbect Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ISAAC First ELDRIDGE Middle COSTLEY Last		4. DATE OF DEATH JUNE Month 29 Day 1959 Year	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-19-1887
9. AGE (In years lost birthday) 72 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY general	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joshua L. Costley		14. MOTHER'S MAIDEN NAME Martha Dykes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 215-14-1261	
INFORMANT Mrs. Ada F. Costley,		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL VASCULAR ACCIDENT DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 6 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMBOLUS, PULMONARY INFARCTION		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 6 , 19 59 , to JUNE 29 , 19 59 , that I last saw the deceased alive on JUNE 29 , 19 59 , and that death occurred at 8:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Evaristo R. Lardizabal M.D.		ADDRESS (Street, city or town, state) 1500 PENNSYLVANIA AVE	
DATE SIGNED 6-30-59			
PHYSICIAN'S NAME (Type) EVARISTO R. LARDIZABAL		HAGERSTOWN MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-3-1959	22c. NAME OF CEMETERY OR CREMATORY White Rock	22d. LOCATION (City, town, or county) (State) Carroll Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR JUL 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thrall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7298

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Nursing Home</u>		d. STREET ADDRESS <u>124 1/2 W. Franklin St.</u>	
3. NAME OF DECEASED (Type or print) <u>BESSIE</u> First <u>MAY</u> Middle <u>CREBS</u> Last		4. DATE OF DEATH <u>June 14</u> 19 <u>59</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/14/1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Wm. Higman</u>		14. MOTHER'S MAIDEN NAME <u>Nannie V. Knode</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>315-14-1269</u>	
17. INFORMANT <u>Mrs. Vernon Beard - Hagerstown, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tabo-paresia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cystitis--pyelitis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>13 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1946</u> to <u>June 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 12</u> , 19 <u>59</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above. D.S.T. ADDRESS (Street, city or town, state) <u>100 Professional Arts Bldg. 6/15/59</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Wm. T. Layman</u> M.D.		100 Professional Arts Bldg. 6/15/59	
PHYSICIAN'S NAME (Type) <u>William T. Layman</u>		<u>Hagerstown</u> <u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Woodford T. Norment - Hagerstown Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 18 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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7243

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07238

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 915 Mulberry Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DONALD Middle RICHARD Last DAILEY, JR.		4. DATE OF DEATH Month June Day 22 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 14, 1954
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Donald R. Dailey, Sr.		14. MOTHER'S MAIDEN NAME Helen Nuna Kephart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Donald R. Dailey, Sr.		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO BRONCHO PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MUCOVISCIDOSIS DUE TO (c) BIRTH		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 week BIRTH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 0 m 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-30 , 19 54 , to 6-22 , 19 59 , that I last saw the deceased alive on 6-21 , 19 59 , and that death occurred at 2 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. Margaret Sullivan M.D.		ADDRESS (Street, city or town, state) 314 N. Potomac St. DATE SIGNED 6-22-59	
PHYSICIAN'S NAME (Type) E. Margaret Sullivan, M. D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/24/1959	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR JUN 25 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

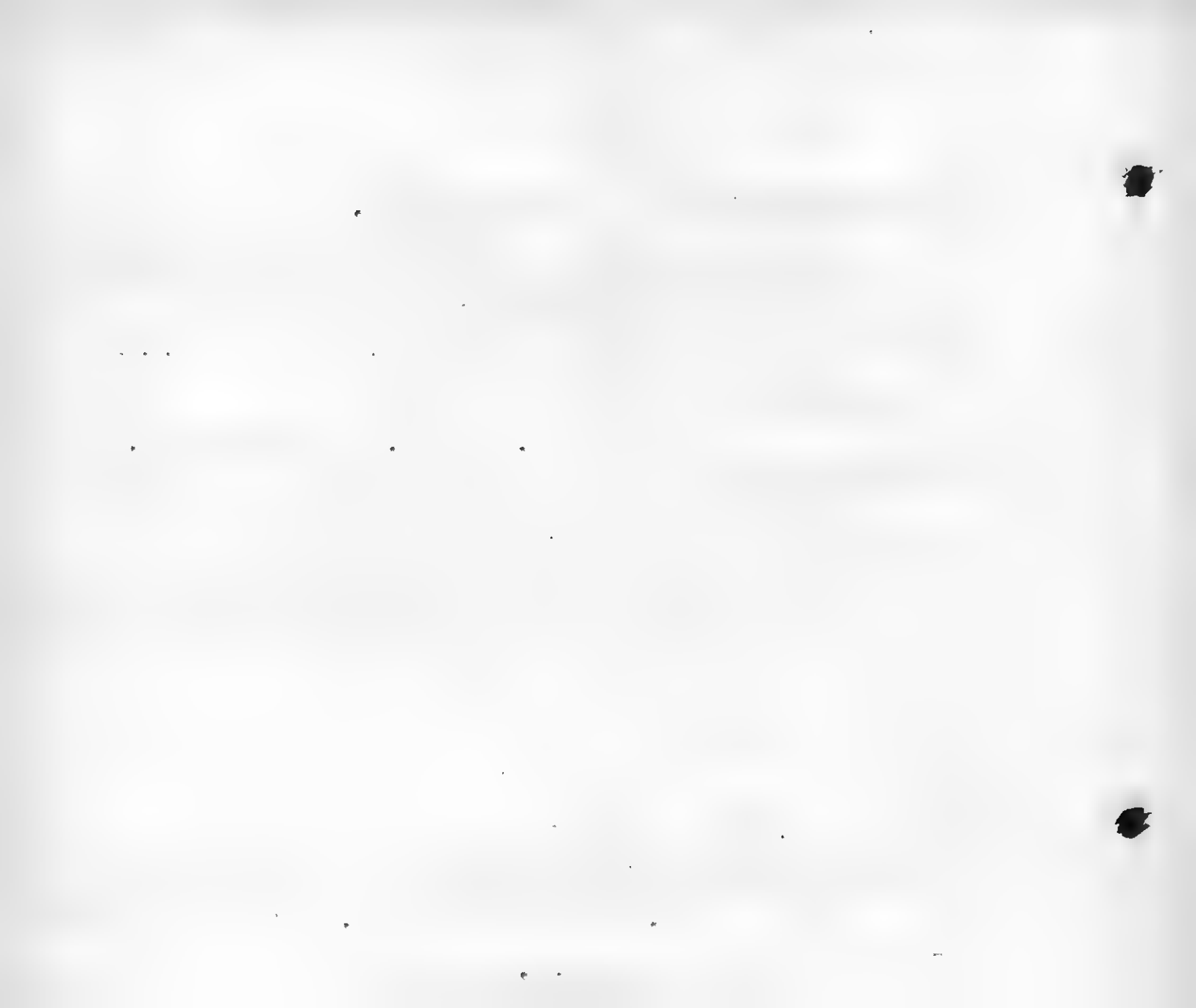
7244

CERTIFICATE OF DEATH

07239

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MINNIE Middle VIOLA Last DAVIS				4. DATE OF DEATH Month June Day 12 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1884	9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	IF UNDER 5 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Knitter		10b. KIND OF BUSINESS OR INDUSTRY Knitting mill		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Davis				14. MOTHER'S MAIDEN NAME Anna Hose			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Margie St. John Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolus, bilateral 466X DUE TO Phlebothrombosis, iliac Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) less than 8 d DUE TO (c) less than 8 d							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease; cholecystitis; cholelithiasis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 9 a. m. 19 p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 19 59 to June 12 19 59 , that I last saw the deceased alive on June 11 19 59 , and that death occurred at 8:12A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 318 North Potomac Street, Hagerstown, Md. DATE SIGNED 6-12-59							
ACTUAL SIGNATURE Robert F. Keadle M.D.		PHYSICIAN'S NAME (Type) Robert F. Keadle 318 North Potomac Street, Hagerstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/1959		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) St. Paul's Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Houzer Funeral Home				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			



7245

CERTIFICATE OF DEATH

07240

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>16 Hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. STREET ADDRESS <u>Hagerstown #5</u>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>A.</u> Last <u>DEAL</u>				4. DATE OF DEATH Month <u>June</u> Day <u>26</u> , Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/21/1914</u>	9. AGE (In years last birthday) <u>44</u> yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild</u>		11. BIRTHPLACE (State or foreign country) <u>Smithsburg #2 Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Samuel A. Deal</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Kipe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>188-09-5301</u>		17. INFORMANT Address <u>Mrs. Edward A. Deal, Smithsburg #5, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY Occlusion</u> DUE TO <u>CHRONIC DIVERTICULITIS of THE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Sigmoid Colon</u> DUE TO <u>Sigmoid Colon</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sigmoid Colectomy</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1/2 HR</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 5</u> , 19 <u>59</u> , to <u>JUNE 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JUNE 26</u> , 19 <u>59</u> , and that death occurred at <u>_____</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John A. Moran</u>				ADDRESS (Street, city or town, state) <u>215 W Washington St Hagerstown Md.</u>			
PHYSICIAN'S NAME (Type) <u>JOHNA. MORAN</u>				DATE SIGNED <u>6/26/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Washington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Love</u> ADDRESS <u>Haynesboro, Pa</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Amos & Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7246

CERTIFICATE OF DEATH

07241

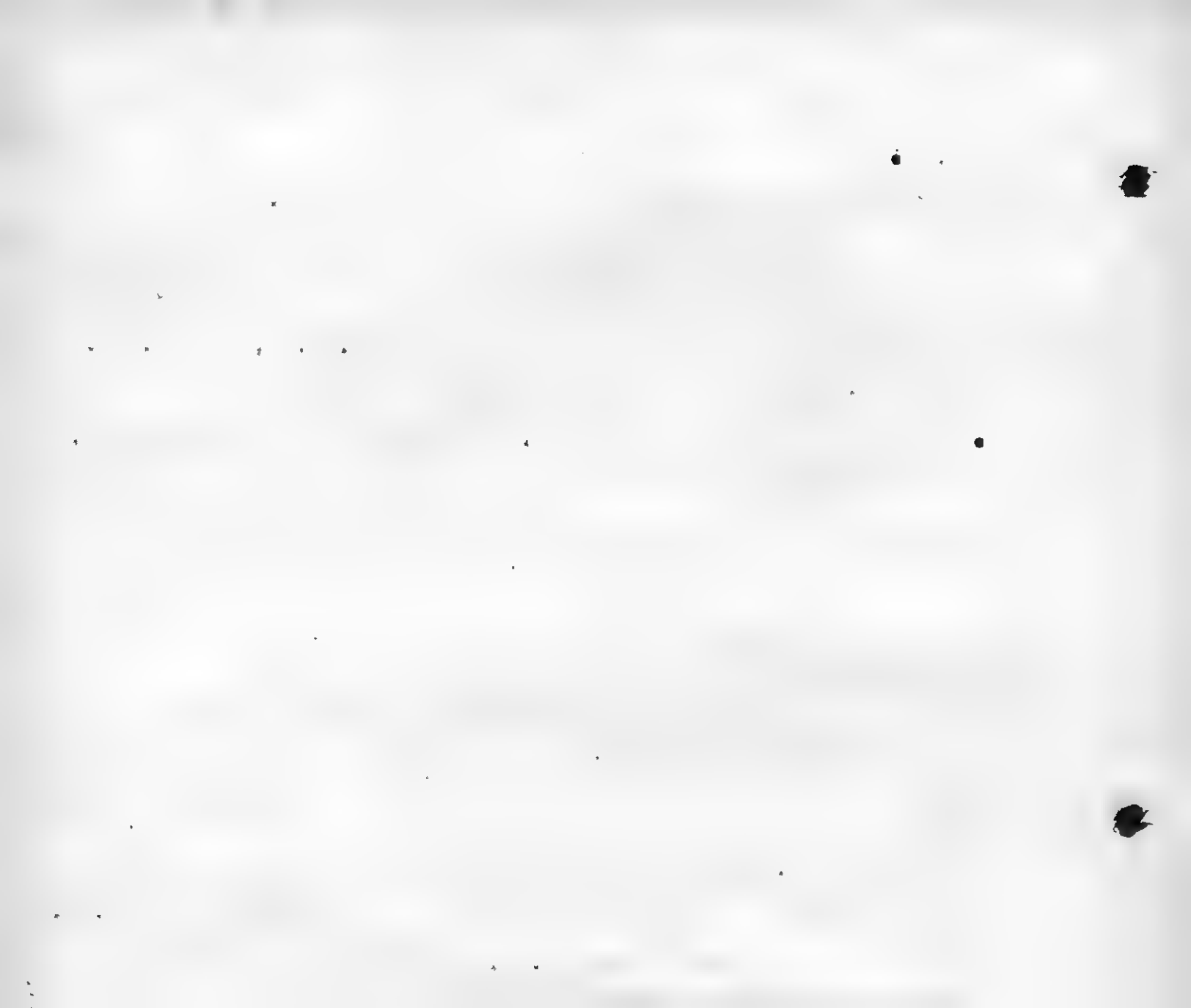
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Md b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 16 8 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Convalescent Hospital				d. STREET ADDRESS 417 Clarendon Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Edna Middle Butts Last DeHaven				4. DATE OF DEATH Month June Day 4 Year 19 59				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1882		
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 3 Days 3		IF UNDER 24 HRS Hours Min 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House duties			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Berkeley Co. W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Silas H. Butts				14. MOTHER'S MAIDEN NAME Saloma Albright				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Address Mrs. Olive Manford 417 Clarendon Ave.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auricular fibrillation 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic and Hypertensive cardiovascular disease. DUE TO vascular disease. (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of sigmoid suspected but not proved.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 17, 1954 , to June 4, 1959 , that I last saw the deceased alive on June 4, 1959 , and that death occurred at 10:30 PM from the causes and on the date stated above ADDRESS (Street, city or town, state) 100 Professional Arts Bldg. 6/6/59 DATE SIGNED								
ACTUAL SIGNATURE William T. Layman				M.D. 100 Professional Arts Bldg. 6/6/59				
PHYSICIAN'S NAME (Type) William T. Layman				Hagerstown Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/7/59		22c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		22d. LOCATION (City, town, or county) (State) Martinsburg W.Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown				ADDRESS Martinsburg W.Va.		24a. REC'D BY REGISTRAR DATE JUN 8 59		
				24b. REGISTRAR'S SIGNATURE Robert S. Hulse				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G244 6-22-59 et

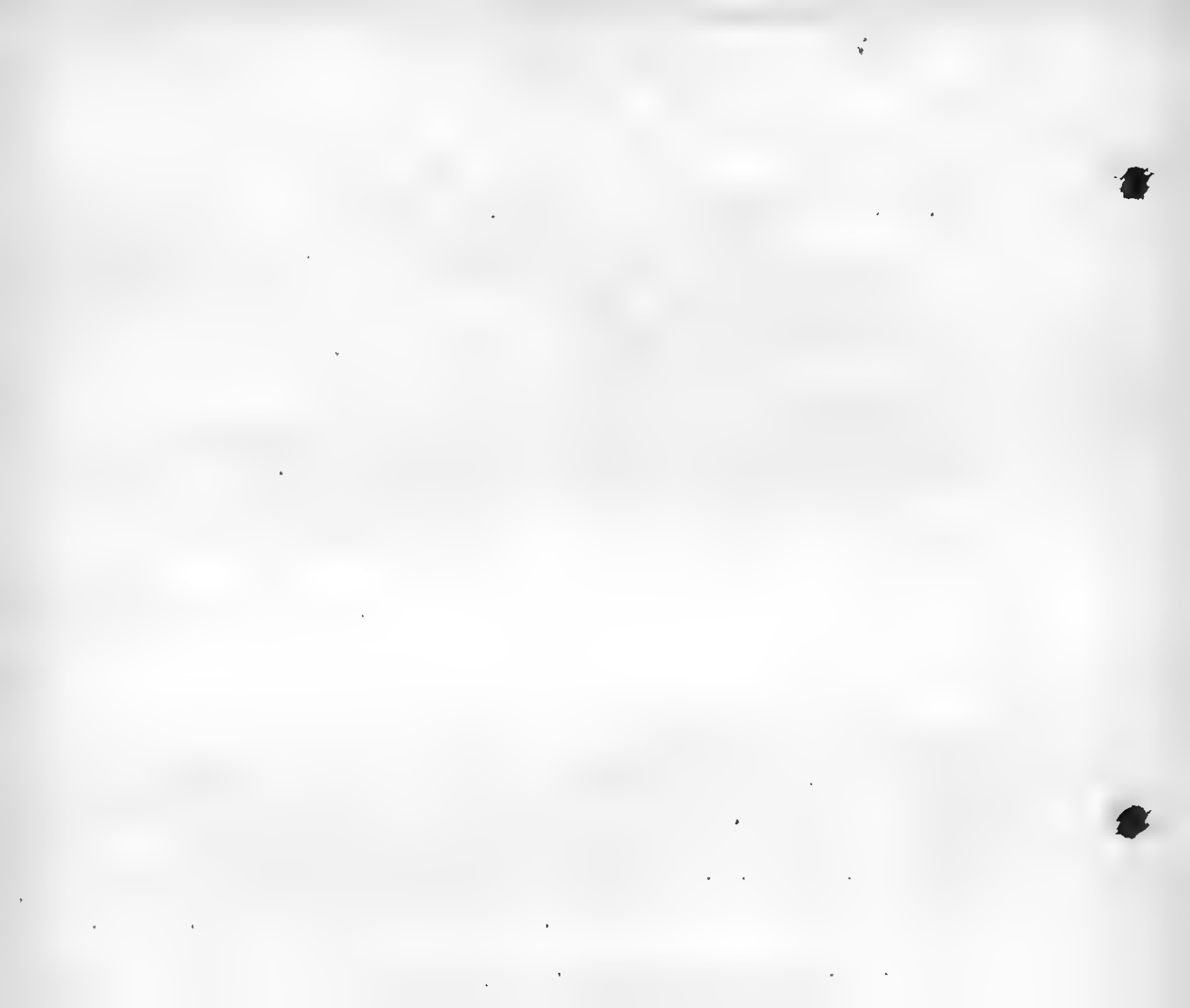
7247

CERTIFICATE OF DEATH

Reg. Dist. No.

07242
303

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE BURNS DELOSIER		4. DATE OF DEATH Month Day Year June 13 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 10 1865
9. AGE (In years last birthday) 93 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Tracey		14. MOTHER'S MAIDEN NAME Mary Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs Lillian Brown		Address 930E Main Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia DUE TO Cerebral Vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anterior cerebral artery aneurysm (c) INTERVAL BETWEEN ONSET AND DEATH 3 wks. 3 wks. years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 17, 1959, to June 13, 1959, that I last saw the deceased alive on May 12, 1959, and that death occurred at 10:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE D. J. Boyer		ADDRESS (Street, city or town, state) 135 N. Potomac Street, Hagerstown, Maryland	
PHYSICIAN'S NAME (Type) D. J. Boyer, M.D.		DATE SIGNED 6/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/16/59	22c. NAME OF CEMETERY OR CREMATORY Bethel U.B. Cemetery	22d. LOCATION (City, town, or county) (State) Foxville Fred. Co Md.
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE JUN 17 '59		24b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7248

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07243

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Church Home		d. STREET ADDRESS 5701 Nasco Place	
3. NAME OF DECEASED (Type or print) First KATHERINE Middle DRAGER Last DRAGER		4. DATE OF DEATH Month June Day 30 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1887
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR: Months 71 Days 71 Hours 71 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY self Employed	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman Grief		14. MOTHER'S MAIDEN NAME Mary Seegnuber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Rev. Mark Wagner	
17. INFORMANT Hagerstown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart exhaustion + collapse 422.1 DUE TO cardiovascular. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cardiovascular. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 30, 19 59 to June 30, 19 59 , that I last saw the deceased alive on June 30, 19 59 , and that death occurred at 7:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED 7/1/59			
ACTUAL SIGNATURE Louis G. Graff M.D.		DATE SIGNED 7/1/59	
PHYSICIAN'S NAME (Type) Louis G. Graff M.D.		DATE SIGNED 7/1/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/1959	
22c. NAME OF CEMETERY OR CREMATORY Baltimore, Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE JUL 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

7249

CERTIFICATE OF DEATH

07244

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1164 Hamilton Blvd.		d. STREET ADDRESS 1164 Hamilton Blvd.	
3. NAME OF DECEASED (Type or print) First CLAUDE Middle LINWOOD Last DUNHAM		4. DATE OF DEATH Month JUNE Day 26 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1877
9. AGE (In years last birthday) 81 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Woolen Co.	
11. BIRTHPLACE (State or foreign country) Berkeley Co., W. Va.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Washington Taylor Dunham		14. MOTHER'S MAIDEN NAME May Catherine Pine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Willie Frank Dunham 1164 Hamilton Blvd., Hagerstown, Md.	
17. INFORMANT Willie Frank Dunham 1164 Hamilton Blvd., Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis. (c) Years.		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 21, 1959 , to June 26, 1959 , that I last saw the deceased alive on June 23, 1959 , and that death occurred at 4:30AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 119 North Potomac Street. DATE SIGNED 6-26-59			
ACTUAL SIGNATURE R.A. Bell		M.D. 119 North Potomac Street.	
PHYSICIAN'S NAME (Type) R.A. Bell, M.D.		Hagerstown, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-28-1959	22c. NAME OF CEMETERY OR CREMATORY New Norborne Cemetery	22d. LOCATION (City, town, or county) (State) Martinsburg, West Va.
23. FUNERAL DIRECTOR'S SIGNATURE Howard N. Brown		ADDRESS Martinsburg, W. Va.	
24a. REC'D BY REGISTRAR DATE JUN 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. H. 111	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

7250

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 E-11-59 or

CERTIFICATE OF DEATH

07245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>7 wks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>43 West Baltimore St</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>L.</u> Last <u>Etter</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/14/1885</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>4</u> Hours <u>15</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Etter</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hollinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>unable to obtain</u>	
17. INFORMANT <u>Mr. Aaron Ette</u>		Address <u>State Line, Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal Carcinomatosis</u> <u>12</u> (Primary site undeterminable) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Note: Proved by laparotomy & biopsy</u> DUE TO (c) <u>9 mos.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-1-</u> 19 <u>39</u> to <u>6-5-</u> 19 <u>59</u> , that I last saw the deceased alive on <u>6-4-59</u> , 19 <u>59</u> , and that death occurred at <u>12:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.C. Brewer</u>		ADDRESS (Street, city or town, state) <u>359 E. Baltimore St., Greencastle, Pa.</u>	
DATE SIGNED <u>6/5/59</u>			
PHYSICIAN'S NAME (Type) <u>W.C. Brewer, M.D.</u>		<u>359 E. Baltimore St., Greencastle, Pa.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/7/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Welsh Run Brethorn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Franklin Co. Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman, Greencastle, Pa</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frawley</u>			



7251

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07246

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY York			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spring Grove	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Church Home				d. STREET ADDRESS none		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARIE Middle B. Last FAUST				4. DATE OF DEATH Month June Day 27 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1876		9. AGE (In years last birthday) yrs 83	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Mins 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edwin H. Bickel				14. MOTHER'S MAIDEN NAME Sarah Amada Scholl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Rev. Mark Wagner Address Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x DUE TO cardiac vascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis, gen DUE TO hypertension (c) hypertension							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour 19 Month June Day 27 Year 1959			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 26 , 19 59 , to June 27 , 19 59 , that I last saw the deceased alive on June 26 , 19 59 , and that death occurred at 7:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 E. Main St. Hagerstown, Md. DATE SIGNED 6/29/59							
ACTUAL SIGNATURE Louis E. Craff M.D.							
PHYSICIAN'S NAME (Type) Louis E. Craff							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/1/1959		22c. NAME OF CEMETERY OR CREMATORY Leschey's Union Cemetery		22d. LOCATION (City, town, or county) (State) York County, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Inter-Rouzer Funeral Home				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 30 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7252

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07247

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm'ssion) b. STATE Maryland c. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN lb 52 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 311 Jefferson St				d. STREET ADDRESS 311 Jefferson St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last FAVORITE				4. DATE OF DEATH Month June Day 30 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 27 1874	
9. AGE (In years last birthday) 84 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles R. H. Fouke				14. MOTHER'S MAIDEN NAME Delilah Clugston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs Mary A. Brenner 311 Jefferson St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast with metastasis to lungs and liver DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost Hypertensive cardio-vascular disease DUE TO Arteriosclerotic myocardial heart failure grade iv (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Hour o. m. none Day, Year 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I attended the deceased from Oct. 1953 to June 30 1959 , that I last saw the deceased alive on June 30 1959 , and that death occurred at 10:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Robert Wells		M.D. 115 N. Potomac Street		DATE SIGNED 7-1-59			
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.				Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVA, (Specify) Burial		22b. DATE THEREOF 7/3/59		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR JUL 7 1959		24b. REGISTRAR'S SIGNATURE William S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

7299

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

07248

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll Co</u>			
c. LENGTH OF STAY IN 1b <u>4 yrs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Id.</u>			
3. NAME OF DECEASED (Type or print) First <u>Amanda</u> Middle <u>Elizabeth</u> Last <u>Harner</u>				4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1873</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penn</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Samuel Meyer</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)				16. SOCIAL SECURITY NO		17. INFORMANT <u>Mrs Ruth Harwarder Union Bridge</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Choked with food</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4500</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 20</u> 19 <u>59</u> , to <u>June 28</u> 19 <u>59</u> , that I last saw the deceased alive on <u>June 26</u> 19 <u>59</u> , and that death occurred at <u>7 1/2</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>V. W. Tolson</u> M.D.				ADDRESS (Street, city or town, state) <u>Boonsboro</u> DATE SIGNED <u>7/8/59</u>			
PHYSICIAN'S NAME (Type) <u>William L. Leary</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-30-59</u>		<u>Meadow Branch</u>		<u>Near Westminster Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond K. Wright Union Bridge</u> ADDRESS				24a. REC'D BY REGISTRAR <u>JUN 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7253

CERTIFICATE OF DEATH

07249

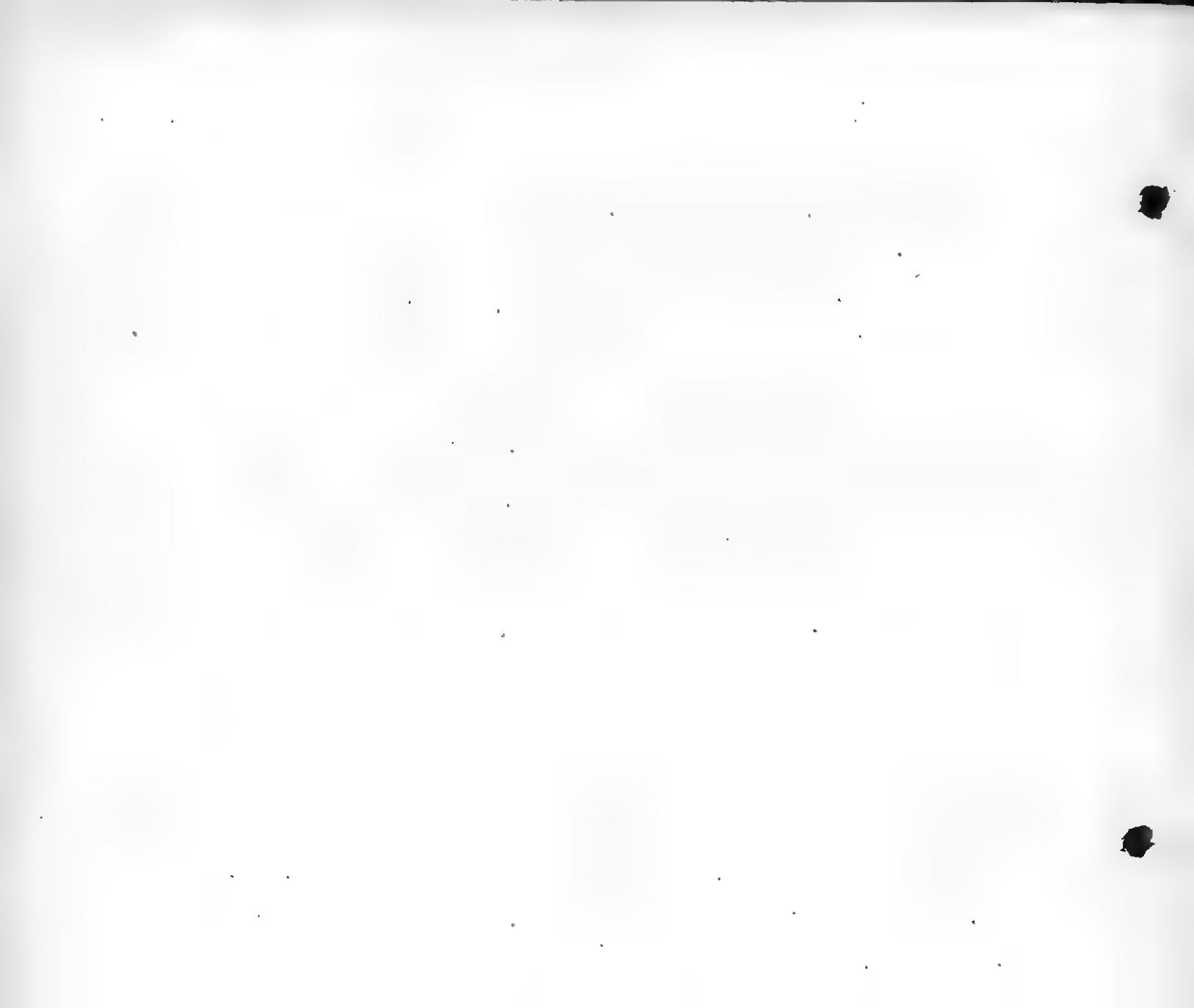
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. State Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>(ISAHEL) ISABELLE BOWEN</u> Middle Last		4. DATE OF DEATH <u>JUNE 11</u> 19 <u>59</u> Month Day Year	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
13. FATHER'S NAME <u>John Steelberg</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-26-5047</u> Address <u>Mr. Robert Mouat, 400 E. 30th Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u> DUE TO <u>PORTAL CIRRHOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>UNKNOWN</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombocytopenic purpura, Rheumatic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 14</u> , 19 <u>59</u> , to <u>JUNE 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JUNE 11</u> , 19 <u>59</u> , and that death occurred at <u>12:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Evaristo R. Lardizabal</u> M.D.		DATE SIGNED <u>6-11-59</u>	
PHYSICIAN'S NAME (Type) <u>Evaristo R. Lardizabal</u> <u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>JUN 15 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Clara S. Hines</u>	

MEDICAL CERTIFICATION

2

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

VS A15 (4)
ISM 9/58

7300

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07250

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown		c. LENGTH OF STAY IN 1b 5 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) Gateway Nursing Home		e. STREET ADDRESS 17 N. Locust St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bertha Middle Nora Last Grove		4. DATE OF DEATH Month June Day 30 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 20, 1880
9. AGE (In years birthdate) yrs. 78		IF UNDER 1 YEAR Months 7 Days 10 Hours 15 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Nichols		14. MOTHER'S MAIDEN NAME Mary Boward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
INFORMANT Robert H. Grove, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coduna by Throm Boos 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/29/59 to 6/30/59 , that I last saw the deceased alive on 6/30/59 , and that death occurred at 4:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph L. Young		DATE SIGNED 6/27/59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, or MOVEMENT (Specify) burial		22b. DATE THEREOF 7-2-59	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
24b. REGISTRAR'S SIGNATURE C. L. L. L.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII A15 (4)
15M 9/58

7254

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07251

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 1/2 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle (NONE) Last GROVE		4. DATE OF DEATH Month June Day 10 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1878
9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Lived with brother	
11. BIRTHPLACE (State or foreign country) Frederick County, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Grove		14. MOTHER'S MAIDEN NAME Sally Duffey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Marshall Grove		Address Hagerstown, Md. R#2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia - terminal - 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis and DUE TO arteriosclerotic heart disease (c) arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 4 days 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 9, 1959 to June 10, 1959 , that I last saw the deceased alive on June 9, 1959 and that death occurred at 12:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 217 W. Washington St. DATE SIGNED 6-11-59			
ACTUAL SIGNATURE Edward W. Ditto M.D.		PHYSICIAN'S NAME (Type) Edward W. Ditto M.D. Hagerstown, Maryland	
22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF June 13, 1959	22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery	22d. LOCATION (City, town, or county) (State) Winchester Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 15 59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

Wm. G. Horak U-Proc.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7255

CERTIFICATE OF DEATH

07252

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 212 Willard Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First PAUL Middle LESTER Last GUESSFORD				4. DATE OF DEATH Month June Day 6 Year 19 59				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16, 1913		
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months 10 Days 20		IF UNDER 24 HRS Hours Min 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver			10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (State or foreign country) Washington County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer Guessford				14. MOTHER'S MAIDEN NAME Stella Rubeck				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) in the 30's		17. INFORMANT Mrs. Bertha Guessford		Address Hagerstown, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Uremia 12x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Chronic Glomerulonephritis with Hypertension DUE TO (c) unknown							INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 10 , 19 59 to June 6 , 19 59 , that I last saw the deceased alive on June 6 , 19 59 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE Archie R. Cohen M.D.								
PHYSICIAN'S NAME (Type) Archie R. Cohen M.D.				Clearspring, Maryland		6/7/59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/1959		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Super-Kouzer Funeral Home				ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR DATE JUN 9 '59		
				24b. REGISTRAR'S SIGNATURE Charles S. Evans				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7256

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07253

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle MC CAMMON Last HARTMAN		4. DATE OF DEATH Month June Day 4 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 4, 1913
9. AGE (In years last birthday) 46 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Moulder	
10b. KIND OF BUSINESS OR INDUSTRY Foundry		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Calvin B. Hartman	
14. MOTHER'S MAIDEN NAME Florence E. Metzger		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. II	
16. SOCIAL SECURITY NO. 214-09-6016		17. INFORMANT Edward L. Hartman Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic hydronephrosis with renal failure 601X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Hypertensive vascular disease and cardiac enlargement			
INTERVAL BETWEEN ONSET AND DEATH Indefinite			
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 56 to June 4, 1959 , that I last saw the deceased alive on June 4, 1959 , and that death occurred at 4:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 148 West Washington St. DATE SIGNED 6/5/59			
ACTUAL SIGNATURE B. B. Kneisley M.D.		PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D. Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/7/1959	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kneisley			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7301

CERTIFICATE OF DEATH

07254

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R#6				c. LENGTH OF STAY IN 1b 6 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reid				d. STREET ADDRESS Reid			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM OWEN HENDRICKSON				4. DATE OF DEATH Month Day Year June 17 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27 1914	9. AGE (In years last birthday) yrs. 45	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Express Co		11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Guy Hendrickson				14. MOTHER'S MAIDEN NAME Anna May Shuckman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-09-4969		17. INFORMANT Address Mrs Dorothy K. Hendrickson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				Hagerstown R # 6 Md Reid		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July , 19 56 , to June 17 , 19 59 that I last saw the deceased alive on June 1 , 19 59 , and that death occurred at 10 3/4 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Paul Harrison M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/59		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR DATE JUN 22 '59		24b. REGISTRAR'S SIGNATURE Orlbert L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07255	
7257 Item 2 FILED 7-6-59										Reg. Dist. No. 302	
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Washington						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Webster Grove				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Church Home					d. STREET ADDRESS 325 Newport Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH HELEN MARTHA HERMANN					4. DATE OF DEATH Month Day Year June 21 19 59						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 9, 1884		9. AGE (In years and birthday) yrs. 74		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Florist				10b. KIND OF BUSINESS OR INDUSTRY Florist		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles M. Hermann					14. MOTHER'S MAIDEN NAME Elizabeth Diehl						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address Homewood Church Home, Same as Item #2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse DUE TO Central vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gen. arteriosclerosis DUE TO (c) Gen. arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 16, 1959 to June 21, 1959 that I last saw the deceased alive on June 19, 1959 , and that death occurred at 3 P. M. from the causes and on the date stated above.											
ACTUAL SIGNATURE Louis G. Graff M.D.				ADDRESS (Street, city or town, State) 119 E. Antietam Hagerstown Md. DATE SIGNED 6/22/59							
PHYSICIAN'S NAME (Type) Louis G. GRAFF											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 25, 1959		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery			22d. LOCATION (City, town, or county) (State) Frederick, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, Frederick, Maryland						24a. REC'D BY REGISTRAR DATE JUN 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

7302

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dargan</u>		c. LENGTH OF STAY IN 1b <u>35 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Residence</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RENO</u> Middle <u>LESTER</u> Last <u>HETZEL</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> , Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 26, 1908</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tester</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Freezer Mfg. Plant</u>	
11. BIRTHPLACE (State or foreign country) <u>Antietam, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Hetzel</u>		14. MOTHER'S MAIDEN NAME <u>Susan Jamison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>220-10-3783</u>	
17. INFORMANT <u>Mrs. Etta Va. Hetzel</u> <u>R.F.D.#1, Harpers Ferry, West Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage, cerebral</u> 391x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive vascular disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> m. <u> </u> <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 15</u> , 19 <u>53</u> , to <u>June 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 1</u> , 19 <u>57</u> , and that death occurred at <u>12:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>206 W. Liberty St., Charles Town, W. Va.</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Donald K. McIntyre</u> M.D.		PHYSICIAN'S NAME (Type) <u>Donald K. McIntyre, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Samples Manor Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>Samples Manor, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 15 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 8 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				/d. STREET ADDRESS Route 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George		First D		Middle Hicks		Last 19 59	
4. DATE OF DEATH 6		Month 7		Day 19		Year	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19, 1886	
9. AGE (In years last birthday) 73		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Lawyer		11. BIRTHPLACE (State or foreign country) Wash. Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cadmus M. Hicks				14. MOTHER'S MAIDEN NAME Mary Dennis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		INFORMANT Mrs. Florence Hicks			
Address Sharpsburg, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6/7, 1959 to 6/7, 1959 that I last saw the deceased alive on 6/7, 1959 and that death occurred at 9:45 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 154 West Washington Street DATE SIGNED 6:8:59 ACTUAL SIGNATURE John H. Hornbaker M.D. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D. Hagerstown, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-10-59		22c. NAME OF CEMETERY OR CREMATORY Rest Haven		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 11 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Krauss			



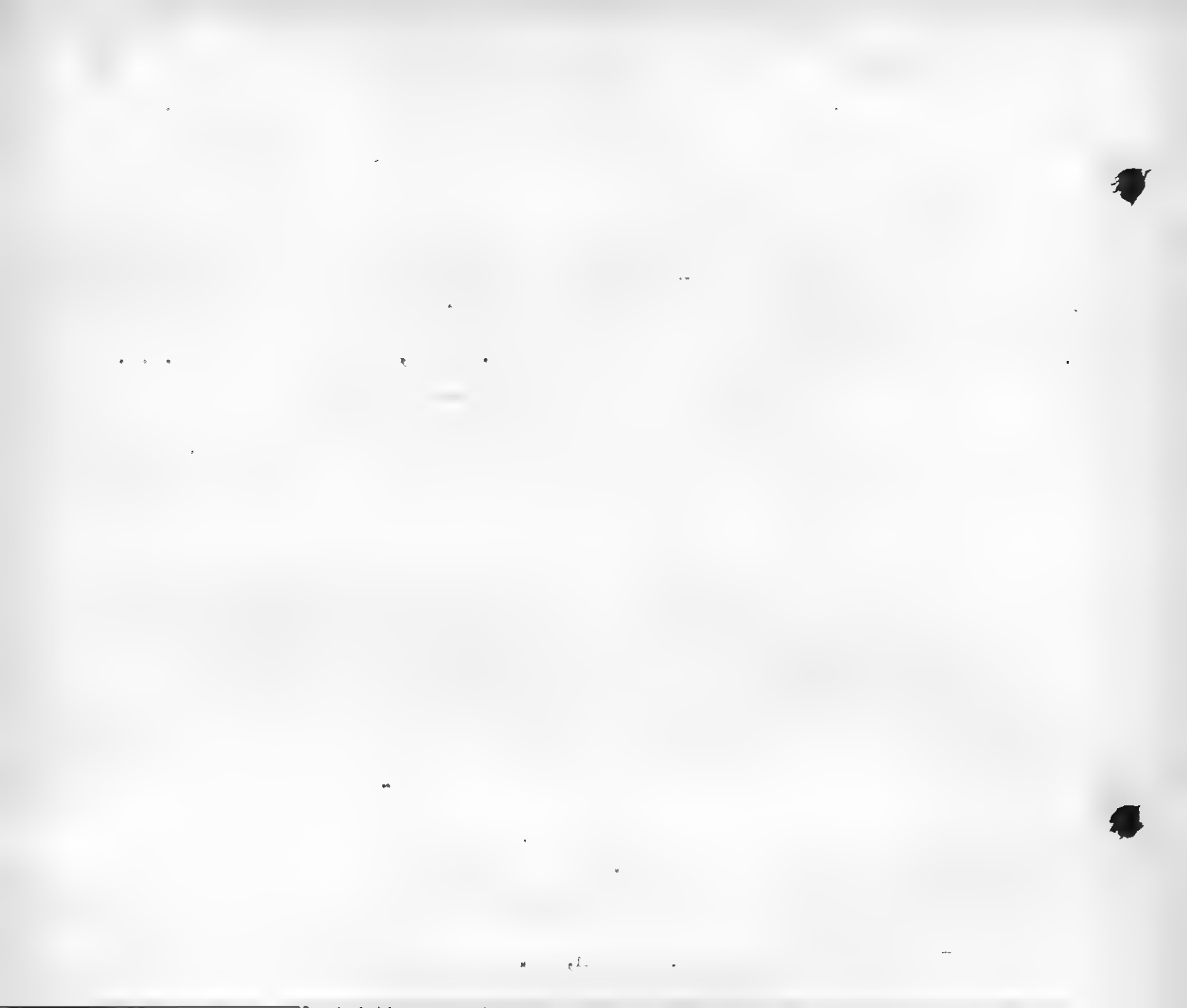
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07258
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 220 Nottingham Road	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DANIEL Middle EDWARD Last HORNBAKER		4. DATE OF DEATH Month June Day 5 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1881
9. AGE (In years last birthday) 77		10. IF UNDER 1 YEAR: Months 7 Days 11 Hours 11 Min. 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY St. James, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Zachery Taylor Hornbaker		14. MOTHER'S MAIDEN NAME Elizabeth Carbaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Elton Hornbaker	
17. INFORMANT Hagerstown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronal hemorrhage DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) pneumonia & heart effusion, emphysema 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/10/56 , 19 56 , to 6/5/59 , 19 59 , that I last saw the deceased alive on 6/4/59 , 19 59 , and that death occurred at 4:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 133 North Potomac St. Hagerstown, Maryland DATE SIGNED 6/1/59			
ACTUAL SIGNATURE Howard J. Woods, M.D.		M.D. 133 North Potomac St. Hagerstown, Maryland	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/1959	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Fouzer Funeral Home		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE JUN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

7303

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07259

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convalescent Home		e. STREET ADDRESS R#3	
3. NAME OF DECEASED (Type or print) First RENA Middle ALICE Last HOUSER		4. DATE OF DEATH Month June Day 13 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1872
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Josephus Wise		14. MOTHER'S MAIDEN NAME Susan Gross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Roy M. Houser R#3		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Arterio Sclerotic Heart Dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterial Sclerosis DUE TO 10 yrs. (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15, 1959 to June 13, 1959 that I last saw the deceased alive on June 12, 1959 and that death occurred at 10:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David R. Brewer M.D.		ADDRESS (Street, city or town, state) Clear Spring Md. DATE SIGNED 6/15/59	
PHYSICIAN'S NAME (Type) David R. Brewer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 16, 1959	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	22d. LOCATION (City, town, or county) (State) Sharpsburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 17 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. K...			

Wm. C. Host & Co. Pres.



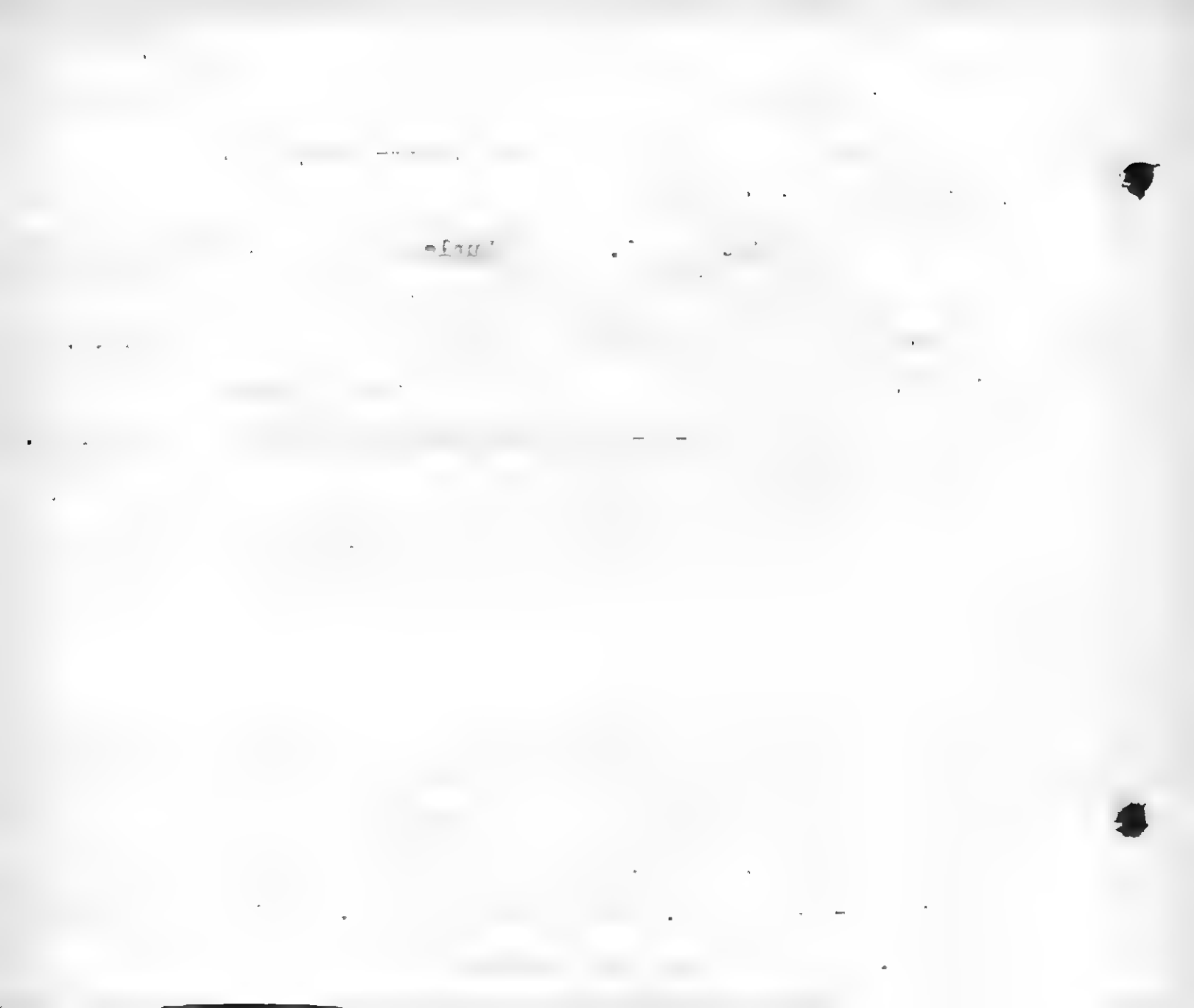
7260

CERTIFICATE OF DEATH

07260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Foxville, Lantz P.O.	
c. LENGTH OF STAY IN 1b 2 days		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle C. Last Hurley		4. DATE OF DEATH Month June Day 10 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1887
9. AGE (In years birth day) 72 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilson Hurley		14. MOTHER'S MAIDEN NAME Genora Draper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-34-1124	
INFORMANT Catherine Lewis Hurley		Address Lantz, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolus 466x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Phlebothrombosis of left iliac vein DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 min. 5 days 5 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-4 , 19 57 , to 6-10 , 19 59 , that I last saw the deceased alive on 6-10 , 19 59 , and that death occurred at 11:55 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. Hess		M.D. Smithsburg, Md. DATE SIGNED 6-11-59	
PHYSICIAN'S NAME (Type) Charles F. Hess M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-13-59	22c. NAME OF CEMETERY OR CREMATORY Mt. Bethel Cemetery	22d. LOCATION (City, town, or county) (State) nr. Garfield Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Maryland	
24a. REC'D BY REGISTRAR June 15 59		24b. REGISTRAR'S SIGNATURE Arthur S. Hous	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07261

7304

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Page	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LuRay	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convalescent Home		d. STREET ADDRESS unknown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLETUS Middle ORVILLE Last KENDRICK		4. DATE OF DEATH Month June Day 5 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1893
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min. 	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jack Kendrick		14. MOTHER'S MAIDEN NAME Rosie Belle Gordon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO 705-19-4761	
17. INFORMANT James O. Kendrick		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 163X DUE TO Carcinoma of Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 3 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6, 1959 to June 4, 1959 , that I last saw the deceased alive on June 4, 1959 , and that death occurred at 12:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE David R. Brewer M.D.		ADDRESS (Street, city or town, state) Clear Spring Md. DATE SIGNED 6/5/59	
PHYSICIAN'S NAME (Type) David Brewer		Clearspring, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/8/1959	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Super-Houzer Funeral Home		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR JUN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7261

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07262

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 34 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1100 So Potomac St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARVEY Middle DENTON Last KLINE				4. DATE OF DEATH Month June Day 13 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 23 1895		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Pangborn Corp		11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Kline				14. MOTHER'S MAIDEN NAME Ann McDonough			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 214-09-5994		17. INFORMANT Mrs Frances Kline Address 1100 So Potomac St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 16 mo DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hagerstown Md. INTERVAL BETWEEN ONSET AND DEATH 3 hrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-15-1939 , to 6-13-1959 , that I last saw the deceased alive on 6-1-59 , 19, and that death occurred at 6:15 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) [Signature] DATE SIGNED 6/13/59			
PHYSICIAN'S NAME (Type) DREW H. ITTO				M.D. [Signature]			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/59		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE JUN 17 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kline			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 9/58

7262

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

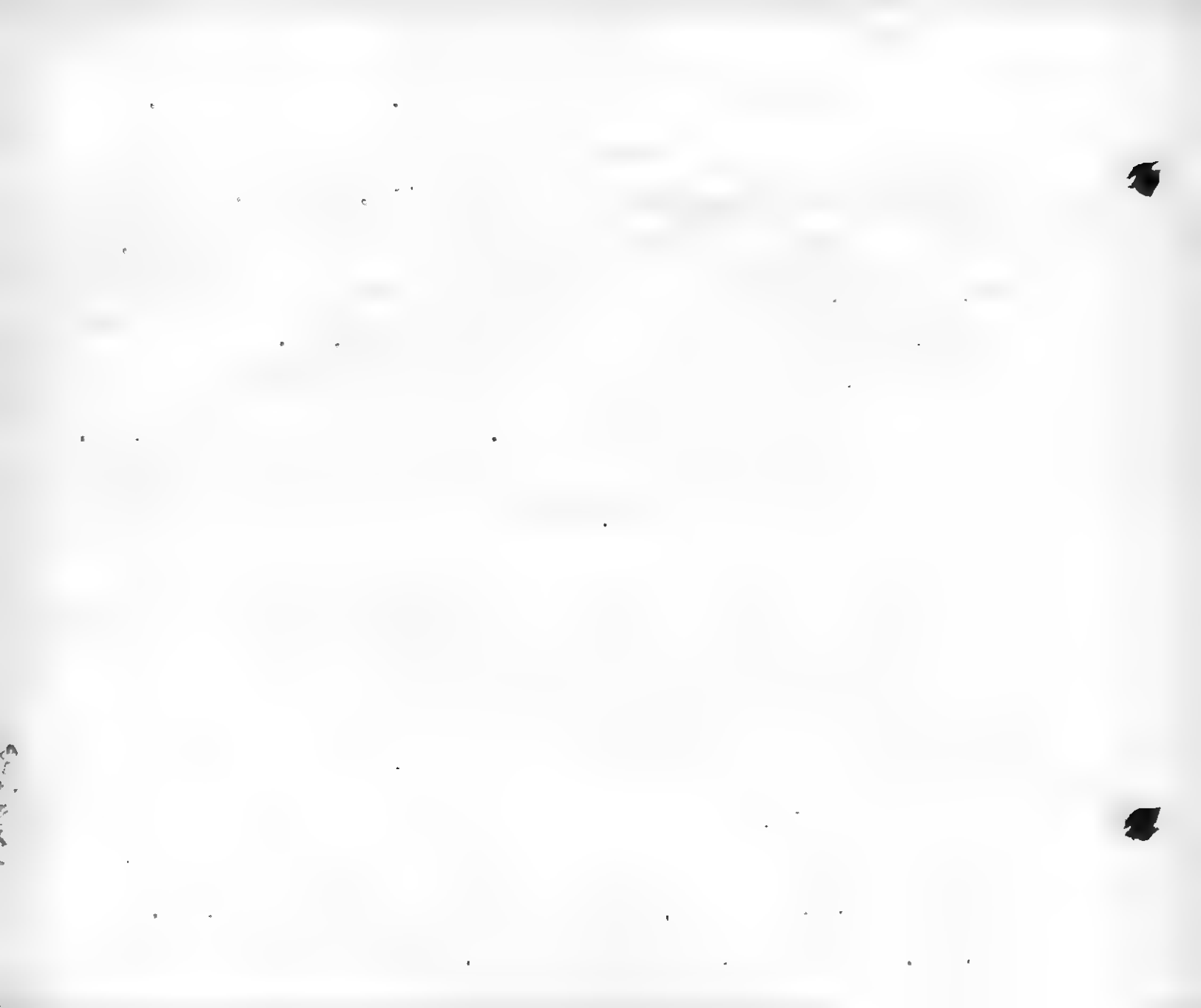
07263

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a STATE Md. b COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN TB 5 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Nora Middle Viola Last Kuhn		4. DATE OF DEATH Month June Day 30 Year 1959	
5 SEX female	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1890
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Clear Spring, Md.		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dallas Ward		14. MOTHER'S MAIDEN NAME Ida Shank	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-38-8720	
17. INFORMANT Address Mrs. Ruth Landis, Hagerstown, Md.			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon with metastases - post operative 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH Two weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-16 , 19 57 , to 6-30 , 19 57 ; that I last saw the deceased alive on 6-30 , 19 59 , and that death occurred at 4:29 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE George Jennings		DATE SIGNED 7/1/59	
PHYSICIAN'S NAME (Type) George Jennings		ADDRESS (Street, city or town, state) 136 W. Washington St. Hagerstown, Md.	
22a. BURIAL, CREMATION, or other disposition (Specify) burial	22b. DATE THEREOF 7-3-59	22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	22d. LOCATION (City, town, or county) (State) Clear Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUL 6 59	24b. REGISTRAR'S SIGNATURE W. H. S. Smith

MEDICAL CERTIFICATION



7263

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07264

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md.</u>		c. LENGTH OF STAY IN TB <u>1 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Maryland State Hosp.</u>		e. STREET ADDRESS <u>2703 Round Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Calvert Landon</u>		4. DATE OF DEATH Month Day Year <u>June 10 1959</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1914</u>
9. AGE (In years lost birthday) <u>45 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Towson, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Sandon</u>		14. MOTHER'S MAIDEN NAME <u>Edythe Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Frances Woody 2703 Round Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema and congestion</u> 44-EX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONFLUENT lobular pneumonia, bilateral</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. cerebrospinal syphilis</u> <u>2. Arteriosclerosis, generalized</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 days</u> <u>6 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 11, 1959</u> , to <u>June 10, 1959</u> , that I last saw the deceased alive on <u>June 10, 1959</u> , and that death occurred at <u>5:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Victor L. Ramos</u> M.D.		ADDRESS (Street, city or town, state) <u>Western Md. State Hospital</u> DATE SIGNED <u>June 10, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Victor L. Ramos</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6-15-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	22d. LOCATION (City, town, or county) (State) <u>Celery Hill, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas E. Kelso</u> ADDRESS <u>1303</u>		24a. REC'D BY REGISTRAR DATE <u>6/12/59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. Ramos</u>

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital, or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

7264

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

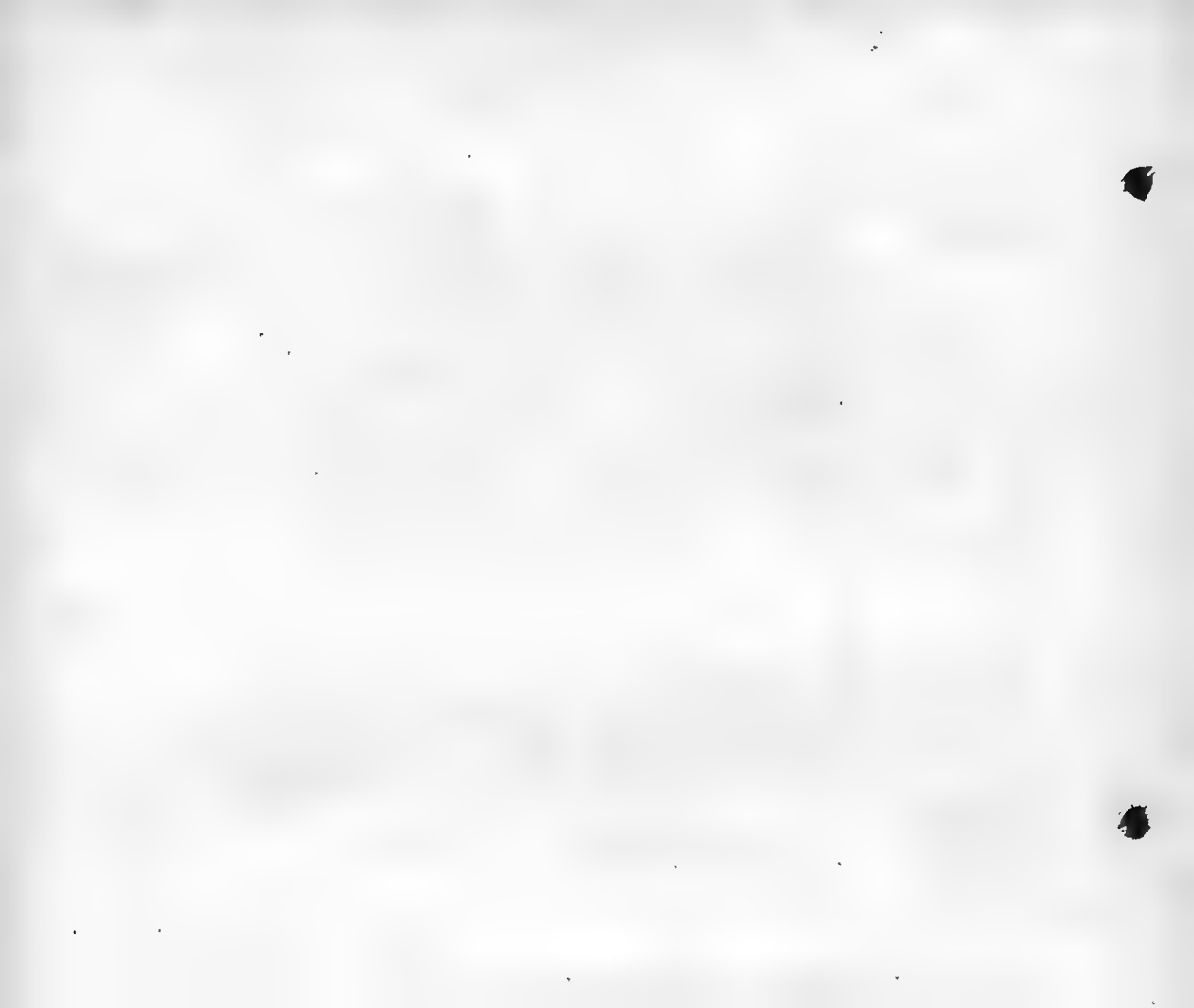
07265

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution Residence before admission] STATE <u>Maryland</u> COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>40 Yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospita, give street address) <u>2006 Virginia Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>MILDRED</u> Last <u>LeFEVRE</u>		4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 4 1880</u>
9. AGE (In years last birthday) <u>78</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph B. Kneisley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cover</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mary Shilling</u>		Address <u>2425 Jefferson Blvd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>min.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <u>none</u>	20f. (City or town) (County) (State) <u>- - -</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		DATE SIGNED <u>6-9-59</u>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Kenna</u>		24b. REGISTRAR'S SIGNATURE <u>DATE JUN 11 '59</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7265

CERTIFICATE OF DEATH

Reg. Dist. No.

07266

302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 Hr d. NAME OF HOSPITAL (If not in hospital, give street address) Wash. County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg R # 2 d. STREET ADDRESS Chewsville e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RHODA HOOVER LEHMAN		4. DATE OF DEATH Month Day Year June 26 1959 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 9 1903
9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Hoover		14. MOTHER'S MAIDEN NAME Linnie Leorone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 219-20-2143	
17. INFORMANT Harold F. Lehman		Address Smithsburg Md R #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vascular Accident DUE TO (c) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH minutes minutes minutes.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis General			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19 59 to June 26 19 59 that I last saw the deceased alive on June 26 19 59 , and that death occurred at 9 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 119 E. Antietam St. 6-27-59 ACTUAL SIGNATURE Louis G. Graff M.D. 6-27-59 PHYSICIAN'S NAME (Type) Louis G. Graff, M.D. Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/59	
22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		22d. LOCATION (City, town, or county) (State) Waynesboro Franklin Co Pa	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE JUL 6 59		24b. REGISTRAR'S SIGNATURE Arthur S. Thrush	

FOR STATE
HEALTH DEPT.

7305

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07267

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilson Md		c. LENGTH OF STAY IN 1b 3 month	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Gateway Convalescent Home		e. STREET ADDRESS 428 Carrollton Ave.	
3. NAME OF DECEASED (Type or print) First William Middle Jacob Last Loveless		4. DATE OF DEATH Month June Day 22 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26 1878
9. AGE (In years last birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	
11. BIRTHPLACE (State or foreign country) Front Royal Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Harvey Loveless		14. MOTHER'S MAIDEN NAME Eliza Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-18-8849	
17. INFORMANT Mr. Joseph Loveless		18. ADDRESS 440 Carrollton Ave. Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma rectum			
DUE TO Arteriosclerotic myocardial heart disease			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) None	
20c. TIME OF INJURY Month, Day, Year Hour None o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		DATE SIGNED 6-24-59	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 24-59	22c. NAME OF CEMETERY OR CREMATORY Bakersville Cemetery	22d. LOCATION (City, town, or county) (State) Bakersville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Williamsport Md		24a. REC'D BY REGISTRAR JUN 26 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. JOHN STAUFFER
145 S. PROSPECT ST.
HAGERSTOWN, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07268

7266

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>MASON</u> Last <u>MASON</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 17 - 1915</u>
9. AGE (In years last birthday) <u>43 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC, FINEFROG FARMER SUPPLY CO.</u>	
11. BIRTHPLACE (State or foreign country) <u>PHILADELPHIA PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY MASON</u>		14. MOTHER'S MAIDEN NAME <u>NO RECORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>220-16-2340</u>	
17. INFORMANT <u>MRS. FLORIDA MASON HAGERSTOWN</u>		Address <u>401 DAYCOTAH AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute carditis with dilatation</u> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic heart disease</u> DUE TO (c) <u>BRONCHITIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchitis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>p. m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/7</u> , 19 <u>58</u> , to <u>6/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/17</u> , 19 <u>59</u> , and that death occurred at <u>4 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Stauffer</u>		DATE SIGNED <u>6/19/59</u>	
PHYSICIAN'S NAME (Type) <u>John C. Stauffer, M.D.</u>		ADDRESS (Street, city or town, state) <u>145 S. Prospect St. Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JUNE 20 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>		ADDRESS <u>BOONSBORO MD.</u>	
24a. REC'D BY REGISTRAR <u>JUN 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanna</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

7306

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07269

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fiddlersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fiddlersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---		d. STREET ADDRESS ---	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Andrew Jackson McAllister</u>		4. DATE OF DEATH Month Day Year <u>June 1 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1906</u>
9. AGE (In years last birthday) <u>52 yrs</u>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) <u>Clearspring, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Archibald McAllister</u>		14. MOTHER'S MAIDEN NAME <u>Emma Suffecool</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W.W. 2</u>		16. SOCIAL SECURITY NO. <u>213-16-1352</u>	
17. INFORMANT <u>Mrs. Susie Hull</u>		Address <u>Hagerstown, Md.</u> <u>425 Indiana Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO Chronic severe asthma Compensatory emphysema Advanced TBC of lungs inactive Conditions, if any, which gave rise to immediate cause (b) <u>Chronic severe asthma</u> (c) <u>Compensatory emphysema</u> (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Hour a. m. p. <u>None</u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		DATE SIGNED <u>6-2-59</u>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/4/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		22d. LOCATION (City, town, or county) <u>nr. Clearspring, Wash. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>June 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7267 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07270
CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) HAGERSTOWN				c. LENGTH OF STAY IN life LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 139 E. ANTILTA ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BLRTHA ANN McKENNA				4. DATE OF DEATH Month Day Year JUNE 1 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/4/1881	
9. AGE (In years last birthday) 77 yn.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SHOE FINISHER				10b. KIND OF BUSINESS OR INDUSTRY SHOE MFG. CO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JAMES P. McKENNA				14. MOTHER'S MAIDEN NAME SARAH LLEN BOWERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 214-09-0559A		17. INFORMANT MISS ALTRUDE McKINNA		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arrhythmia & Fibrillation DUE TO (c) Arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH 2 days 1 wk 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-1- 19 57 , to 6-1-59 , 19 59 , that I last saw the deceased alive on 5-31-59 , 19 59 , and that death occurred at 7:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 318 N. Potomac St. DATE SIGNED 6-2-59							
ACTUAL SIGNATURE Paul Harrison M.D.				DATE SIGNED 6-2-59			
PHYSICIAN'S NAME (Type) Paul Harrison, M.D.				ADDRESS Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/3/59		22c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEM.		22d. LOCATION (City, town, or county) (State) WASHINGTON CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W.J. Norment				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 4 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7307

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07271

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport,		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A.— at office of Dr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 2229 Virginia Avenue	
3. NAME OF DECEASED (Type or print) First Charles Middle Vincent Last McKenna		4. DATE OF DEATH Month June Day 8 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 26, 1879
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Clearspring, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James P. McKenna		14. MOTHER'S MAIDEN NAME Sarah Ellen Bowers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT Miss Madeline McKenna		Address Hagerstown, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH Min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. None p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-11-59	
22c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery		22d. LOCATION (City, town, or county) (State) Western Pike -Hagerstown, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Normant Fun. Home, Hagerstown, Md		ADDRESS	
24a. REC'D BY REGISTRAR DATE JUN 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7308

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 18 & 21 - 18-5-7/23/59 - mb

07272

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN LENGTH OF STAY IN 1b 60YRS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARLOCK MEM. CONV. HOSP				d. STREET ADDRESS 139 E. ANTIETAM ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last McKENNA				4. DATE OF DEATH Month JUNE Day 27 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-11-1873		9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES P. McKENNA				14. MOTHER'S MAIDEN NAME SARAH ELLEN BOWERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE		17. INFORMANT Address MASS ALTRUDE McKENNA, HAGERSTOWN, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis							2 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic disease, cerebral and generalized							Indefinite
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1955 , to 6-27-59 , 19____, that I last saw the deceased alive on 6-26-59 , 19____, and that death occurred at 7 A.M. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul Harrison				ADDRESS (Street, city or town, state) 318 N. Potomac St. Hagerstown, Md.		DATE SIGNED 7-6-59	
PHYSICIAN'S NAME (Type) Paul Harrison, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-29-59		22c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horne				24a. REC'D BY REGISTRAR JUL 10 '59		24b. REGISTRAR'S SIGNATURE William S. Horne	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

7309

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07273

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE Maryland b COUNTY Washington	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 9 mo.	
c CITY OR TOWN (f outside corporate limits, write RURAL and give nearest town) Hagerstown		d STREET ADDRESS 1110 Corbett St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle VALENTINE Last MONG SR.		4. DATE OF DEATH Month June Day 28 Year 19 59	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec. 16, 1885
9 AGE (In years last birthday) 73 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b KIND OF BUSINESS OR INDUSTRY Foundry	
11 BIRTHPLACE (State or foreign country) Waynesboro, Penna.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Mong		14 MOTHER'S MAIDEN NAME Rebecca Bowser	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv. etc.) No		16. SOCIAL SECURITY NO 214-09-5942	
INFORMANT Geo. V. Mong Jr. R#1 Hagerstown, Md.		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Cardiac Valvular Dis 422.1 DUE TO Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 yrs DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 8 mo 5 yrs			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a m p. m 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 27, 1958 to June 28, 1959 that I last saw the deceased alive on June 27, 1959 , and that death occurred at 7:59 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE David R. Brewer M.D. ADDRESS Clear Spring Md 6/29/59 DATE SIGNED PHYSICIAN'S NAME (Type) David R. Brewer			
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b DATE THEREOF 6/30/59	
22c NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d LOCATION (City, town, or county) (State) Hagerstown Md.	
23 FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funera l Chapel Inc. Hagerstown, Md.		24a REC'D BY REGISTRAR DATE JUL 1 '59	
24b REGISTRAR'S SIGNATURE Arthur E. Thoms			

Wm G. Hunt C-Phys.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7268

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07274

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN IB 54 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 23 High St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS First Howard Middle Moulden Last		4. DATE OF DEATH JUNE Month 5 Day 1959 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1872
9. AGE (In years last birthday) 86 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dynamiter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Rappahannock Co. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mauncher Moulden		14. MOTHER'S MAIDEN NAME Jane (Last name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 214-09-4881	
17. INFORMANT Miss Hazel Moulden		Address 23 High St. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 1 YEAR		INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 22 , 19 59 , to JUNE 5 , 19 59 , that I last saw the deceased alive on JUNE 5 , 19 59 , and that death occurred at 1230 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Evaristo R. Lardizabal M.D.		ADDRESS (Street city or town, state) 1500 Pennsylvania AVE	
DATE SIGNED 6-5-59			
PHYSICIAN'S NAME (Type) Evaristo R. Lardizabal		Hagerstown, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/8/59	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. A. Hunt - Vice Pres.		ADDRESS Rest Haven Funeral Chapel Inc. Hagerstown, Md.	
24a. REC'D BY REGISTRAR JUN 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hana	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7310

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg Md.		c. LENGTH OF STAY IN 1b 82 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 135 W. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nancy Middle L Last Mumma		4. DATE OF DEATH Month June Day 25 Year 1959	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20 1877
9. AGE (In years last birthday) yrs 82		10. IF UNDER 1 YEAR Months 1 Days 4 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S.A. Gov.	
11. BIRTHPLACE (State or foreign country) Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Samuel Mumma		14. MOTHER'S MAIDEN NAME Frances Reichard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO No	
17. INFORMANT Miss. Bertha Mumma		Address 135 W. Main St. Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardio vascular disease DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 19 54 to June 25 19 59 that I last saw the deceased alive on June 24 19 59 and that death occurred at 1 A M, from the causes and on the date stated above ADDRESS (Street, city or town, state) June 27, 1959 DATE SIGNED			
ACTUAL SIGNATURE Walter H. Shealy M.D.		June 27, 1959	
PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.		Sharpsburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 27-59	
22c. NAME OF CEMETERY OR CREMATORY Mumma Cemetery		22d. LOCATION (City, town, or county) (State) Near Sharpsburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf		24a. REC'D BY REGISTRAR DATE JUN 30 '59	
24b. REGISTRAR'S SIGNATURE Orlinda S. House			



7269

CERTIFICATE OF DEATH

07276

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Boonsboro R # 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				d. STREET ADDRESS Manor Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Unnamed Baby Girl Nave				4. DATE OF DEATH Month Day Year June 10 1959 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10 1959	
9. AGE (In years last birthday) yrs. 4		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles LeRoy Nave				14. MOTHER'S MAIDEN NAME Isabelle Younkens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address Charles L. Nave Boonsboro Md R # 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus 752x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							INTERVAL BETWEEN ONSET AND DEATH 4 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 115 King St. Hagerstown		20g. (County) Washington		20h. (State) Md.		20i. (Date) 6-10-59	
21. I certify that I attended the deceased from 6-10-59 to 6-10-59 , that I last saw the deceased alive on 6-10-59 , and that death occurred at 4:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel F. Waddill, M.D.				DATE SIGNED 115 King St. Hagerstown 6-10-59			
PHYSICIAN'S NAME (Type) Samuel F. Waddill, M. D.,				115 King St. Hagerstown, Md 6-10-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/59		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR DATE JUN 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

7270

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 52 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home		e. STREET ADDRESS 213 High St	
3. NAME OF DECEASED (Type or print) First Middle Last Rama Blanche Niemyer		4. DATE OF DEATH Month Day Year June 17 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1884
9. AGE (in years lost birthday) yrs 74		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jacob Mose		14. MOTHER'S MAIDEN NAME Ada L. Ecton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-34-3844	
INFORMANT William V. Niemyer		Address Route 5	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 443X Hypertensive Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary - uterus DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 20, 1959 to June 17, 1959 , that I last saw the deceased alive on June 13, 1959 , and that death occurred at 6 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Phillip J. Hirshman		M.D. 159 W. Washington St	
PHYSICIAN'S NAME (Type) Phillip J. Hirshman		Hagerstown Md.	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF 6-19-59	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	22d. LOCATION (City, town or county) (State) Sharpsburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR JUN 22 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7311

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07278

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Shepherdstown		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac River Bridge-Shepherdstown		d. STREET ADDRESS 224 Boyd Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Curtis Last Owens		4. DATE OF DEATH Month June Day 30 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1948
9. AGE (In years last birthday) 10 yrs.		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	IF UNDER 24 HRS. Months 10 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Student	11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Clark Owens	
14. MOTHER'S MAIDEN NAME Audrey Risban		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT William Clark Owens Address 224 Boyd St. Martinsburg, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Asphyxia by drowning 129.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 129.8 DUE TO (c) 129.8			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 129.8			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned while swimming in Potomac River	
20c. TIME OF INJURY Hour 6 p. m. Month, Day, Year June 30 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River		20f. (City or town) Rural-Shepherdstown-Wash (County) Md (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		DATE SIGNED 7-1-59	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-3-1959	22c. NAME OF CEMETERY OR CREMATORY Falling Waters Presbyterian	22d. LOCATION (City, town, or county) Berkeley Co., W. Va. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. Brown		24a. REC'D BY REGISTRAR JUL 2 '59 DATE	
ADDRESS Martinsburg, W. Va.		24b. REGISTRAR'S SIGNATURE Orthur S. Hand	



7312

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07279

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Res dence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Hagerstown	
c. LENGTH OF STAY IN TB 1 Day		d. STREET ADDRESS Sharpsburg #1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOWARD Middle SYLVESTER Last PATTERSON		4. DATE OF DEATH Month JUNE Day 27 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/4/1890
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Thurmont Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME David Patterson	
14. MOTHER'S MAIDEN NAME Margaret Patterson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes War 1	
16. SOCIAL SECURITY NO		17. INFORMANT Address Mrs. Joseph Misner, Waynesboro Pa., #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) COR PULMONALE 527.1 DUE TO Pulmonary Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL SPASTIC INFANTILE PARALYSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 26, 1959, to JUNE 27, 1959, that I last saw the deceased alive on JUNE 26, 1959, and that death occurred at 6:25 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Evaristo R. Landigabal M.D.		ADDRESS (Street, city or town, state) 1500 Pennsylvania Ave DATE SIGNED 6-27-59	
PHYSICIAN'S NAME (Type) Evaristo R. Landigabal		Hagerstown, Md	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/30/59	22c. NAME OF CEMETERY OR CREMATORY Green Hill	22d. LOCATION (City, town, or county) (State) Waynesboro, Franklin Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Grove, Waynesboro Pa.		24a. REC'D BY REGISTRAR DATE JUN 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thorne			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07280

7271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Pa. b. COUNTY Franklin			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 13 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro 757 3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 347 W. 2nd. St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN EDWARD PEIFFER JR. First Middle Last				4. DATE OF DEATH Month June Day 25 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/24/1879	
9. AGE (In years last birthday) 79 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hutcher Business		11. BIRTHPLACE (State or foreign country) Grindstone Hill		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Peiffer				14. MOTHER'S MAIDEN NAME Fianna Wingert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address John E. Peiffer Jr., 347 W. 2nd. St., Waynesboro Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia. Pulmonary infarction							INTERVAL BETWEEN ONSET AND DEATH 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/15, 1959 to 6/25, 1959 , that I last saw the deceased alive on 6/25, 1959 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 154 W. WASHINGTON ST. HAGERSTOWN, MD. DATE SIGNED 6/26/59							
ACTUAL SIGNATURE John H. Hornbaker M.D.							
PHYSICIAN'S NAME (Type) JOHN H. HORNBAKER, MD HAGERSTOWN, MD							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/59		22c. NAME OF CEMETERY OR CREMATORY Green Hill		22d. LOCATION (City, town, or county) (State) Waynesboro, Franklin Co. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Grove, Waynesboro Pa				24a. REC'D BY REGISTRAR DATE JUN 30 1959		24b. REGISTRAR'S SIGNATURE William S. K...	

7313

CERTIFICATE OF DEATH

07281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg Md.		c. LENGTH OF STAY IN 1b 15 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Antietam Station		e. STREET ADDRESS Near Antietam Station	
3. NAME OF DECEASED (Type or print) First Alfred Middle Mc Kinley Last Petefish		4. DATE OF DEATH Month June Day 27 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22 1906
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 3 Days 4	11. IF UNDER 24 HRS. Hours 3 Min. 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Section Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Stanley Va		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Vernon Lee Petefish		14. MOTHER'S MAIDEN NAME Minnie Aleshire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 719 07 6489	
17. INFORMANT Mrs. Mabel Petefish		18. ADDRESS (Street, city or town, state) Near Antietam Station Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) Cerebral Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 15 MIN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-27-59 to 6-27-59 that I last saw the deceased alive on 6-27-59 and that death occurred at 3:00 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE William Shepherd		DATE SIGNED 6-27-59	
PHYSICIAN'S NAME (Type) William Shepherd			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF June 30-59	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	22d. LOCATION (City, town, or county) (State) Sharpsburg Maryland
23. FUNERAL DIRECTOR'S SIGNATURE William Shepherd		24a. REC'D BY REGISTRAR DATE JUN 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Knead			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOCUST GROVE - RURAL		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOCUST GROVE - RURAL		d. STREET ADDRESS 1 ROBBERSVILLE MD 2.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION JOHN H. WILLIAMS MD. D.C.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
ALFRED CLARENCE ROEBER							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan-22-1893	
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months 4 Days 25		11. IF UNDER 24 HRS Hours 4 Min 25		12. DATE OF DEATH JUNE-17-1959	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PESTICIDE OPERATOR OF COUNTRY STORE		10b. KIND OF BUSINESS OR INDUSTRY LOCUST GROVE WASH. D.C.		11. BIRTHPLACE (State or foreign country) W.D. U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME LAWRENCE ROEBER		14. MOTHER'S MAIDEN NAME MARY SMITH		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO 218-36 9152	
17. INFORMANT MRS. RUTH ROEBER		Address ROBBERSVILLE MD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 20 , 19 58 , to June 18 , 19 59 , that I last saw the deceased alive on June 17 , 19 59 , and that death occurred at 1:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1300 N. 1st St. B. 1000		DATE SIGNED 6/18/59		ACTUAL SIGNATURE G. Wilkerson	
PHYSICIAN'S NAME (Type) G. Wilkerson		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE-20-1959		22c. NAME OF CEMETERY OR CREMATORY LOCUST GROVE CEMETERY	
22d. LOCATION (City, town, or county) (State) LOCUST GROVE WASH. D.C. MD		23. FUNERAL DIRECTOR'S SIGNATURE John H. Best		ADDRESS BOONSBORO MD		24a. REC'D BY REGISTRAR JUN 23 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank							



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

7272

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

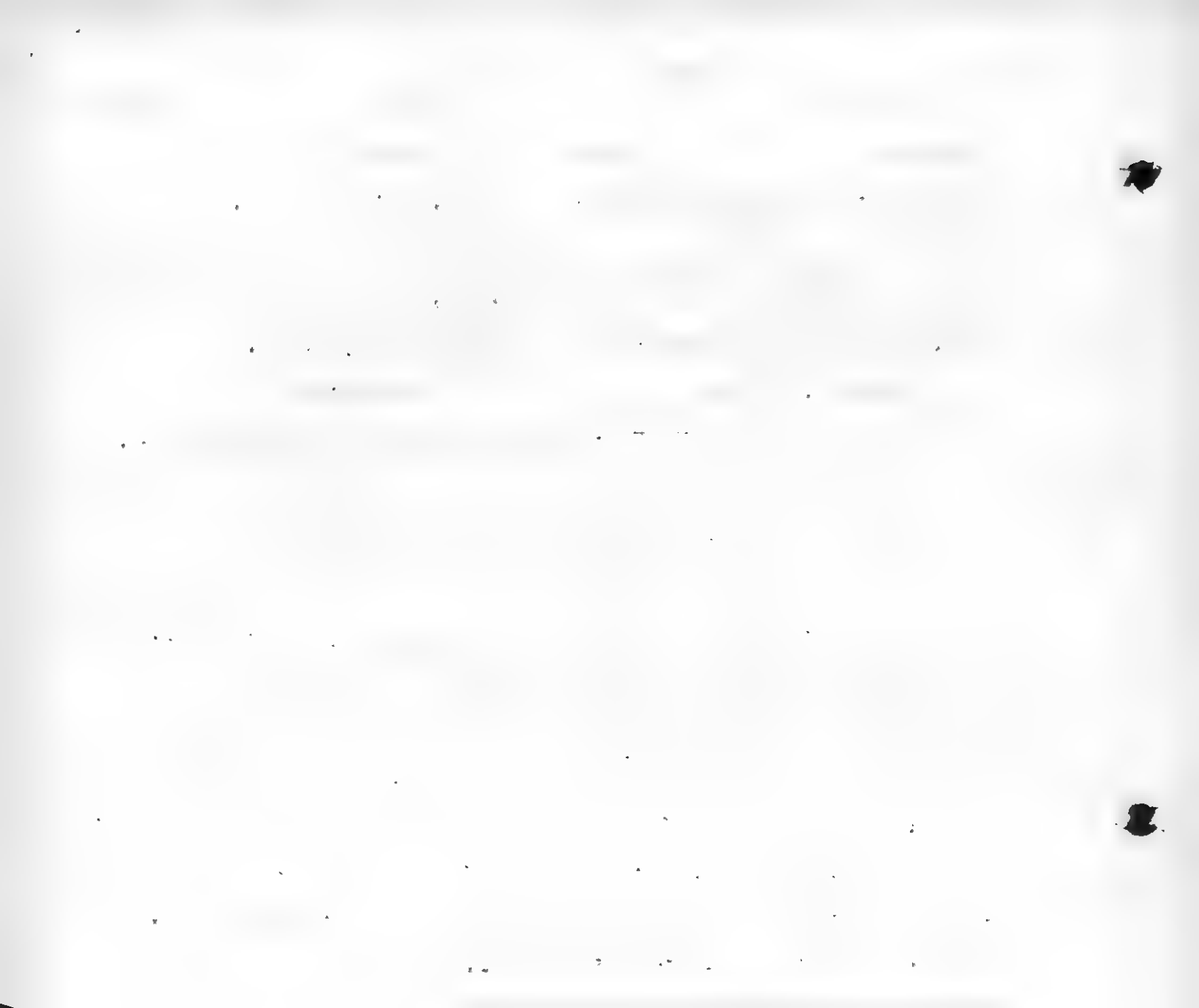
07283

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 408 W. Washington Street				e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FREDERICK Middle CLINTON Last PRICE				4. DATE OF DEATH Month June Day 7 Year 19 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 13, 1880	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 19		IF UNDER 24 HRS Hours 59 Min 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Pipe supply Co.		11. BIRTHPLACE (State or foreign country) Canada	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO unknown		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic myocardial heart disease DUE TO with myocardial failure grade iv; Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. None p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE S. Robert Welle				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Welle, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/10/1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home				ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR JUN 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07284	
Item 18 Film 243 6-11-59 ams											
CERTIFICATE OF DEATH										Reg. Dist. No.	
1 PLACE OF DEATH a. COUNTY Washington 7273 MARYLAND					2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					c. LENGTH OF STAY IN 1b 45 years					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital					d. STREET ADDRESS 26 W. Baltimore St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) CATHERINE ELIZABETH RICKARD					4. DATE OF DEATH JUNE 5 1959						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 11, 1882		9. AGE (In years, month, day, hour, min.) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife					10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Martinsburg W. Va.			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Martin V. Green					14. MOTHER'S MAIDEN NAME Susan Smith						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 215-26-8480		INFORMANT Clayton Rickard Hagerstown Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF THE OVARY WITH METASTASES DUE TO Carcinoma of ovary with generalized metastases (c)										INTERVAL BETWEEN ONSET AND DEATH 5 days UNKNOWN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIO-VASCULAR DISEASE, BRADYCARDIA										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from APRIL 22 1959 , to JUNE 5 1959 , that I last saw the deceased alive on JUNE 5 1959 , and that death occurred at 8:20 AM , from the causes and on the date stated above											
ACTUAL SIGNATURE Evaristo R. Lardizabal M.D.					ADDRESS (Street, city or town, state) 1500 PENNSYLVANIA AVE HAGERSTOWN Md. DATE SIGNED 6-5-59						
PHYSICIAN'S NAME (Type) Evaristo R. Lardizabal											
22a. BURIAL, CREMATION, or other disposal (Specify) Burial			22b. DATE THEREOF 6-8-59		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			22d. LOCATION (City, town, or county) (State) Hagerstown Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son ADDRESS Hagerstown Md.					24a. REC'D BY REGISTRAR JUN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				



7274

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Film G244 7-20-59 et
CERTIFICATE OF DEATH

07285

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b one hour			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lee Middle Roy Last Rider				4. DATE OF DEATH Month June Day 10 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 16 1907	
9. AGE (in years last birthday) 52 51		10. IF UNDER 1 YEAR Months 6 Days 21		11. IF UNDER 24 HRS Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent				10b. KIND OF BUSINESS OR INDUSTRY Label Mill		11. BIRTHPLACE (State or foreign country) Hagerstown Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Grant Rider				14. MOTHER'S MAIDEN NAME Effie Boward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 215 07 4258		17. INFORMANT Mrs. Catherine Rider			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Codwary Stroke 4-2-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 Day					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19__				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 5/10/59 19__ to 6/10/59 19__, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.							
22. ADDRESS (Street, city or town, state)				23. DATE SIGNED			
ACTUAL SIGNATURE Albert L. Wolf				M.D. William F. Wolf			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 12-59		22c. NAME OF CEMETERY OR CREMATORY Greenlaw Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Wolf				24a. REC'D BY REGISTRAR DATE JUN 1-2 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

7275

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

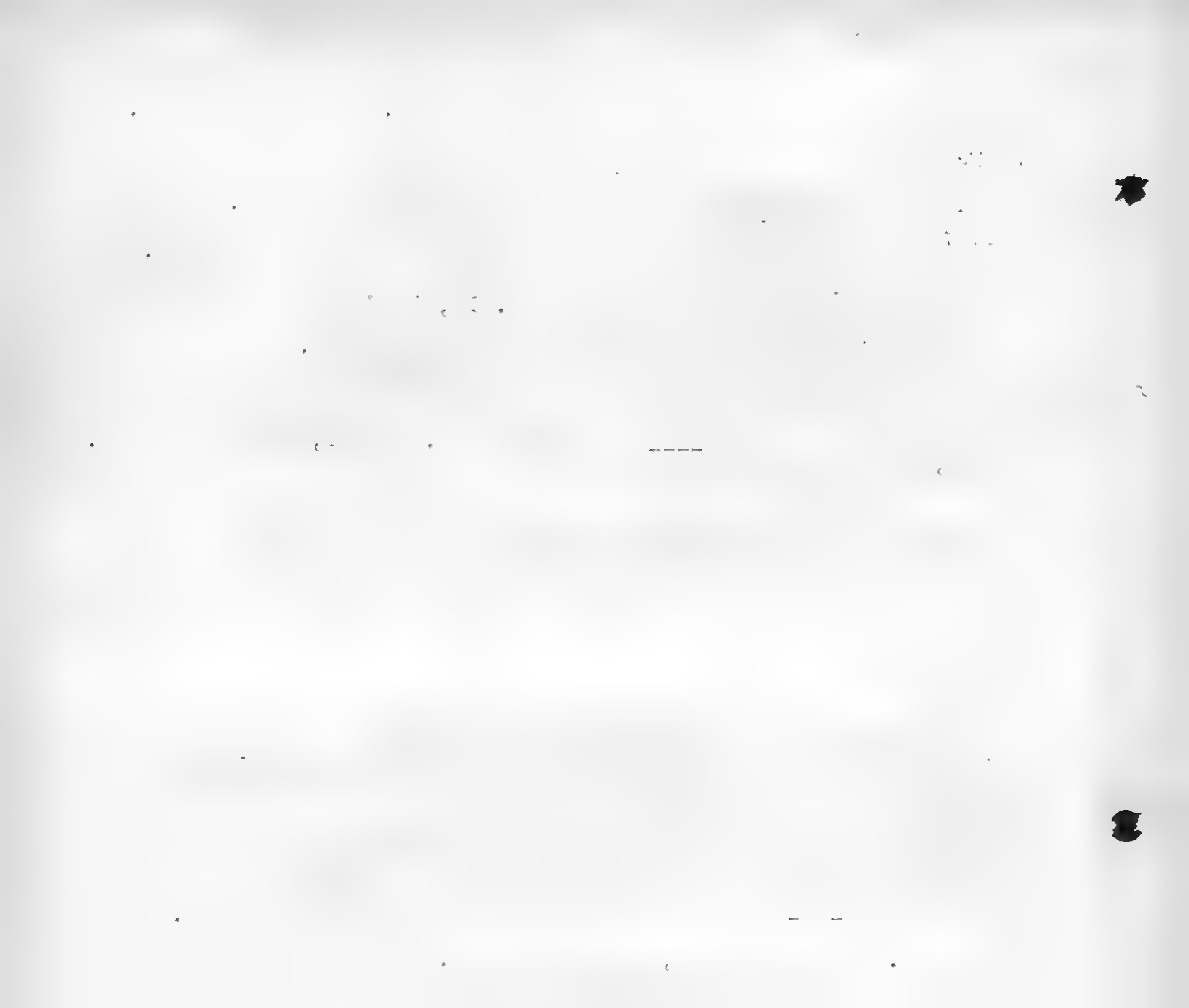
07286

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Emory & Hospital		e. STREET ADDRESS 251 West Side Ave.	
3. NAME OF DECEASED (Type or print) First Ada Middle Pearl Last Ringer		4. DATE OF DEATH Month June Day 24 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1887
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 2 Days 4 Hours 19 Min 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Simon Baker		14. MOTHER'S MAIDEN NAME Laura Ambrose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO ---	
17. INFORMANT Charles K. Ringer, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease (c) 2 yr PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. E. W. Dittto Jr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Dittto Jr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-27-59	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md		ADDRESS	
24a. REC'D BY REGISTRAR JUN 30 59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7276

CERTIFICATE OF DEATH

07287

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 50YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 E. ANTIETAM ST.				d. STREET ADDRESS /101 L. ANTIETAM ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERTHA Middle ALICE Last ROHRER				4. DATE OF DEATH Month JUNE Day 1 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/14/1879		9. AGE (In years last birthday) 80	IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN H. YOUNG				14. MOTHER'S MAIDEN NAME HENRIETTA COFFMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. J. HOWARD POHRER		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 Day						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/3/59 , 19____, to 6/3/59 , 19____, that I last saw the deceased alive on 6/3/59 , 19____, and that death occurred at 2 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Ralph E. Young M.D. ADDRESS (Street, city or town, state) William Street, Hagerstown, Md. DATE SIGNED 6/3/59 PHYSICIAN'S NAME (Type) RALPH E. YOUNG							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/4/59		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. T. Horne				24a. REC'D BY REGISTRAR DATE JUN 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Horne	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7277

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING, MD.	
c. LENGTH OF STAY IN TB 2 DAYS		d. STREET ADDRESS NONE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINERVA Middle ROWLAND Last		4. DATE OF DEATH Month JUNE Day 29 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 12, 1874
9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR: Months 13 Days 15 Hours 15 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home Duties	
11. BIRTHPLACE (State or foreign country) CLEAR SPRING DIST.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEWIS W. SUFFECPOOL		14. MOTHER'S MAIDEN NAME MARY E. REPP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT LAWRENCE ROWLAND		Address CLEAR SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver DUE TO (b) Cirrhosis of Liver (Chronic) DUE TO (c) Cirrhosis of Liver (Chronic) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Alcoholism. End by pneumonia.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 25, 1959 to June 29, 1959 , that I last saw the deceased alive on June 29, 1959 , and that death occurred at 12:00 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. H. Brachley M.D.		DATE SIGNED June 30, 1959	
PHYSICIAN'S NAME (Type) J. H. Brachley			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JULY 2, 1959	22c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY	22d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark		24a. REC'D BY REGISTRAR JUL 6 '59	
ADDRESS Clear Spring, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

7278

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07289

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLETOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u> <u>10 X</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1st ALCOHOLIC HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>C</u> Last <u>RUDY</u>		4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1953</u>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10/28/1906</u>
		9. AGE (in years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>type setter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>newspaper office</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Vera C. Rudy</u>		14. MOTHER'S MAIDEN NAME <u>Ida Clem</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-01-9805</u>	
17. INFORMANT <u>Willard Rudy, Frederick, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John D. Turg</u>		DATE SIGNED <u> </u>	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>6/30/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 30 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Piana</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7279

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 4,22 FilmG24: 6-13-59 et
CERTIFICATE OF DEATH

07290

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 wk d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sh. County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 5 d. STREET ADDRESS Ringgold e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LENA RUSH SACHS				4. DATE OF DEATH 6-8-59 Month Day Year June 8 1959 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 11 1879	
9. AGE (In years last birthday) yrs. 79		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Berne Switzerland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John Rush			
14. MOTHER'S MAIDEN NAME Anna Miller				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs Mary Zello Hagerstown Md R # 5			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 4 days 5 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-4-50 19, to 6-2-50 19, that I last saw the deceased alive on 6-7-59 19, and that death occurred at 3:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Smithsburg, Md. 6-2-50							
ACTUAL SIGNATURE Charles E. Hess M.D. Smithsburg, Md.							
PHYSICIAN'S NAME (Type) Charles E. Hess							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/59		22c. NAME OF CEMETERY OR CREMATORY Adolph Cemetery		22d. LOCATION (City, town, or county) (State) Adolph Randolph Co W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.							
24a. REC'D BY REGISTRAR JUN 11 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Kraus					

7280

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07291

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 5 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARLOCK NURSING HOME		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD. b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CLEAR SPRING d. STREET ADDRESS RT 40 W. CLEAR SPRING e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDITH SERIG		4. DATE OF DEATH Month Day Year 6 29 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 14, 1883
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) W. VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME CHARLES A. STENTZEL		14. MOTHER'S MAIDEN NAME GUSSIE GROSQUE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO (If yes, give war or dates of service) NONE	
17. INFORMANT CHARLES SERIG		Address CLEAR SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 1120.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized arteriosclerosis DUE TO (c) Unk			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 30, 1957 to June 29, 1957 , that I last saw the deceased alive on June 29, 1957 , and that death occurred at 10:50 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 145 W. Washington St. DATE SIGNED 6-30-59			
ACTUAL SIGNATURE L. L. Packer, Jr. M.D.		DATE SIGNED 6-30-59	
PHYSICIAN'S NAME (Type) L. L. Packer, Jr., M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL	22b. DATE THEREOF 7/2/1959	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	22d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark		ADDRESS Clear Spring, Md.	
24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7281

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07292

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>1 Day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SHARAN KAY SHANHOLTZ</u>		4. DATE OF DEATH Month Day Year <u>JUNE - 2 - 19 59</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE - 1 - 19 59</u>
9. AGE (In years last birthday) <u>1</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HAGERSTOWN MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>KENNETH SHANHOLTZ</u>		14. MOTHER'S MAIDEN NAME <u>DIANA MINNICK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>KENNETH SHANHOLTZ</u>		Address <u>HAGERSTOWN MD. R3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Hyaline Membrane</u> <u>773.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from <u>6/1</u> , 19 <u>59</u> , to <u>6/2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/2</u> , 19 <u>59</u> , and that death occurred at <u>7:30</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Richard A. Young</u> M.D. <u>101 Key Street</u> PHYSICIAN'S NAME (Type) <u>Richard A. Young</u> <u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 3 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BEAVER CREEK WASH. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Best</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 8 '59</u>	
ADDRESS <u>BOONSBORO MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Carlyle S. K...</u>	



7282

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		d. STREET ADDRESS <u>112 West Franklin St.</u>	
3. NAME OF DECEASED (Type or print) First <u>DEBORAH</u> Middle <u>JEAN</u> Last <u>SHANK</u>		4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1 1959</u>
9. AGE (In years last birthday) <u>35</u>		IF UNDER 1 YEAR: Months <u>35</u> Days <u>35</u> Hours <u>35</u> Min. <u>35</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Calvin Shank Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Roberta Ellen House</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mrs. Mary House</u>		Address <u>112 W. Franklin St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>35 min.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 1</u> , 1959, to <u>JUNE 1</u> , 1959, that I last saw the deceased alive on <u>June 1</u> , 1959, and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Samuel F. Waddell</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>115 King St. Hagerstown 6-1-59</u>	
PHYSICIAN'S NAME (Type) <u>Samuel F. Waddell</u>		<u>115 King St. Hagerstown</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to a burial, cremation or removal.

7283

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		c. LENGTH OF STAY IN TB 5 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 450 Park Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Richard Wallace Shedd				4. DATE OF DEATH Month Day Year June 27 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 12 1933	
9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sewan, Tennessee	
12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME George Shedd				14. MOTHER'S MAIDEN NAME Nassie Marbury			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. World War-2 408-48-5458		17. INFORMANT Address Phyllis Shedd 450 Park Place	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 1199 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bullet wound of neck penetrating lungs (c) Cuts on large vessels of neck 20 minute PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Accidentally shot by rifle			
20c. TIME OF INJURY Month, Day, Year Hour 6:27 p. m. 6-27-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Handy House Md		20f. (City or town) (County) (State) Washington Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE A. E. W. H. T. T. O. P.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) A. E. W. H. T. T. O. P.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 6/29/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-1-1959		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. Hagerstown Md.				24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE Charles S. H.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07295

7315

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO				c. LENGTH OF STAY IN 1b X FUNKSTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REEDER NURSING HOME				d. STREET ADDRESS 1 STOFFER AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD H. Middle SHIELER Last SHIELER				4. DATE OF DEATH Month JUNE Day 29 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 21, 1969	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR: Months 6 Days 8 Hours Min. 	IF UNDER 24 HRS: Hours Min. 	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER				10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) LOCUST GROVE WASH. CO. MD. U.S.A.	
13. FATHER'S NAME GEORGE SHIELER				14. MOTHER'S MAIDEN NAME ELIZABETH HUFFER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT DAVID E. SHIELER FUNKSTOWN MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from JUNE 15, 1959 , to JUNE 29, 1959 , that I last saw the deceased alive on JUNE 29, 1959 , and that death occurred at 2:00 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boonsboro DATE SIGNED 6/30/59							
ACTUAL SIGNATURE G. Wilkerson M.D.				PHYSICIAN'S NAME (Type) G. Wilkerson			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 2, 1959		22c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY		22d. LOCATION (City, town, or county) (State) LOCUST GROVE WASH. CO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Bost				24a. REC'D BY REGISTRAR DATE JUL 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7284

CERTIFICATE OF DEATH

07296

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE Md b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. Chronic Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) CLAYTON First EMANUEL Middle SHRIVER Last		4. DATE OF DEATH JUNE 30 Month 30 Day 1959 Year	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 29. 1885
9 AGE (In years less birth day) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min 73	IF UNDER 24 HRS Months 73 Days 73 Hours 73 Min 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY on Farms	
11. BIRTHPLACE (State or foreign country) Frederick		12. CITIZEN OF WHAT COUNTRY? U.s.A	
13. FATHER'S NAME Joseph Shriner		14. MOTHER'S MAIDEN NAME Laura Eyler	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO no	
17. INFORMANT Mrs Elsie Wastler		Address Thurmont. MD	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO CEREBROVASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) CEREBROVASCULAR ACCIDENT DUE TO (c) CORONARY THROMBOSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY THROMBOSIS			INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 1 YEAR
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from OCT 6 , 19 58 , to JUNE 30 , 19 59 , that I last saw the deceased alive on JUNE 30 , 19 59 , and that death occurred at 4:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Eugene R. Laddigobal		ADDRESS (Street, city or town, state) 1500 Pennsylvania Ave W 6-30-59	
PHYSICIAN'S NAME (Type) Eugene R. Laddigobal		DATE SIGNED Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 3. 1958	22c. NAME OF CEMETERY OR CREMATORY Mt Tabor Cemetery	22d. LOCATION (City, town, or county) (State) Rocky Ridge MD
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont Md	
24a REC'D BY REGISTRAR JUL 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kiana	

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7285 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07297

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN TB		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. - Washington County Hospital			e. STREET ADDRESS Route 3		
3. NAME OF DECEASED (Type or print) First Middle Last Lewis Thomas Shutters			4. DATE OF DEATH Month Day Year June 9 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug 3, 1896		9. AGE (In years last birthday) 62 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto Repair		11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Shutters			14. MOTHER'S MAIDEN NAME Nannie Thomas		
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 043-07-8655		17. INFORMANT Address Mrs Sylvia Shutters Route 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture abdominal aneurysm (aortic) 4 / x DUE TO Vascular hypertension Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asthma					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None			
20c. TIME OF INJURY Hour o. m. p. m. None 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	20f. (City or town) -	(County) -	(State) -
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE S. Robert Wells			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED
EXAMINER'S NAME (Type) S. Robert Wells, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		6-12-59
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-12-59	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son			ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE JUN 15 '59
			24b. REGISTRAR'S SIGNATURE Orlino L. Harris		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7286

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07298

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) b. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>8 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. Co. Hospital</u>				d. STREET ADDRESS <u>MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD</u> <u>SNYDER</u>				4. DATE OF DEATH Month Day Year <u>JUNE</u> <u>2</u> <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 5 - 1873</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days <u>1</u> <u>27</u>	IF UNDER 24 HRS Hours Min <u></u> <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED KEEPER OF CEMETERY</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WASH. Co. MD. U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>HIRAM SNYDER</u>				14. MOTHER'S MAIDEN NAME <u>LUCINDA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>NONE</u>		17. INFORMANT Address <u>MRS. MINNIE SNYDER KEEDYSVILLE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>610X</u> DUE TO <u>Bilateral hydronephrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertrophy of prostate</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 1959</u> to <u>6-2-1959</u> , that I last saw the deceased alive on <u>6-1-1959</u> , and that death occurred at <u>5:27</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Boonsboro MD.</u> DATE SIGNED <u>Joseph Secondary</u>							
ACTUAL SIGNATURE <u>Joseph Secondary</u> M.D. <u>Boonsboro MD.</u>							
PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARY</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 5 - 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>		22d. LOCATION (City town, or county) (State) <u>KEEDYSVILLE WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bass</u>				ADDRESS <u>Boonsboro MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 8 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Orinus S. Evans</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial/cremation, or removal.

7287

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN, MD.				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. STREET ADDRESS CUMBERLAND ST.			
3. NAME OF DECEASED (Type or print) First Middle Last DAISEY CATHERINE STALEY				4. DATE OF DEATH Month Day Year JUNE 15, 19 59			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 28 1900	9. AGE (In years last birthday) 58 5/8 Yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties		10b. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (State or foreign country) Clear Spring, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH MILLS				14. MOTHER'S MAIDEN NAME BARBARA ELLEN MCCARTHY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address CHARLES STALEY CLEAR SPRING, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple fracture ribs (closed) DUE TO Fractured rt. humerus (closed) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary artery thrombosis - acute DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 113 hrs 113 hrs
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto that struck a tree when forced off road					
20c. TIME OF INJURY Hour 6:20 p. m. Month, Day, Year June 10 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) Rural Clearspring Wash, Md		(County) ST. PAUL	(State) MD.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6-16-59	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JUNE 18, 1959	22c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEM.		22d. LOCATION (City, town, or county) ST. PAUL, MD. NR. CLSPG, MD		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. [illegible]				24a. REC'D BY REGISTRAR JUN 18 59		24b. REGISTRAR'S SIGNATURE Arthur S. [illegible]	

MEDICAL CERTIFICATION

07299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Penna b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. - Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 206 Wayne Avenue	
3. NAME OF DECEASED (Type or print) Marvin First Elwood Middle Stewart Last		4. DATE OF DEATH Month June Day 13 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1917
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Chambersburg, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David H. Stewart		14. MOTHER'S MAIDEN NAME Ida M. Hill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 188-09-5085	
17. INFORMANT Mrs. Catherine Stewart-		Address 206 Wayne Ave. Waynesboro, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest DUE TO Hemothorax; shock; Concussion Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto that failed to negotiate a curve and hit a tree	
20c. TIME OF INJURY Hour 12:30 AM Month, Day, Year June 12, 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Rural Hagerstown Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6-13-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-16-59	
22c. NAME OF CEMETERY OR CREMATORY Harbaugh's Cemetery		22d. LOCATION (City, town, or county) (State) Wash. Township-Franklin Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter H. Hous		ADDRESS Waynesboro Pa	
24a. REC'D BY REGISTRAR DATE JUN 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hous	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7315

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Md.		c. LENGTH OF STAY IN 1b 60 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. STREET ADDRESS 70 W. Main St.	
3. NAME OF DECEASED (Type or print) First Homer Middle Edwin Last Tabler		4. DATE OF DEATH Month 6 Day 9 Year 19 50	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4.25.1881
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR Months 1 Days 15	
11. IF UNDER 24 HRS Hours Min. 		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dr of Medicine		10b. KIND OF BUSINESS OR INDUSTRY Dr of Medicine	
11. BIRTHPLACE (State or foreign country) Bedington W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME E.S. Tabler		14. MOTHER'S MAIDEN NAME Katherine Whitmore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Laura C Tabler		Address 70 W. Main St. Hancock Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerosis DUE TO Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 20 min. 2 yrs 20 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 9, 1959 , to June 9, 1959 , that I last saw the deceased alive on June 9, 1959 , and that death occurred at 10:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank B Thomas III M.D.		ADDRESS (Street, city or town, state) 121 High Street	
PHYSICIAN'S NAME (Type) Frank B. Thomas III, M.D.		DATE SIGNED 6-10-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6.12.59	
22c. NAME OF CEMETERY OR CREMATORY St Thomas Cemetery		22d. LOCATION (City, town, or county) (State) Hancock Washington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Shore Hancock Md.		24a. REC'D BY REGISTRAR DATE JUN 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certifi cate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

7317

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07301

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport			
c. LENGTH OF STAY IN IB 81 yrs.				d. STREET ADDRESS 27 E. Potomac Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 27 E. Potomac Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Jackson Last Taylor				4. DATE OF DEATH Month June Day 11 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17 1867	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months 7 Days 25	IF UNDER 24 HRS Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Owner		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Williamsport Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William Jackson Taylor				14. MOTHER'S MAIDEN NAME Christie Ann Newcomer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		INFORMANT Address Mr. Robert Taylor Williamsport Md RFD 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/10/59 to 6/11/59 , that I last saw the deceased alive on 6/10/59 , and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Williamsport Md DATE SIGNED 6/11/59							
ACTUAL SIGNATURE Robert Taylor		PHYSICIAN'S NAME (Type) William Taylor					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 13-59		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport, Md				24a. REC'D BY REGISTRAR DATE JUN 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION



7288

CERTIFICATE OF DEATH

07302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bakersville Md.	
c. LENGTH OF STAY IN TB 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		f. STREET ADDRESS Bakersville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Vickers Last Vickers		4. DATE OF DEATH Month June Day 17 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16 1879
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 8 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Cumberland Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bowers		14. MOTHER'S MAIDEN NAME Mary Riley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Enoch E. Vickers		Address Bakersville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute & Chronic Cholecystitis & Shock 585X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetics - Cardiomegaly - 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year June 17 1959		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> at school <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Aug 1 1958 to June 17 1959 that I last saw the deceased alive on June 17 1959 , and that death occurred at 1:38 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE M. E. Byrkit		DATE SIGNED 6-18-59	
PHYSICIAN'S NAME (Type) M. E. Byrkit		ADDRESS (Street, city or town, state) 28 W. Potomac Williamsport Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 20-59	22c. NAME OF CEMETERY OR CREMATORY Bakersville Cemetery	22d. LOCATION (City, town, or county) (State) Bakersville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Williamsport Md.		24a. REC'D BY REGISTRAR DATE JUN 22 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. House	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

7318

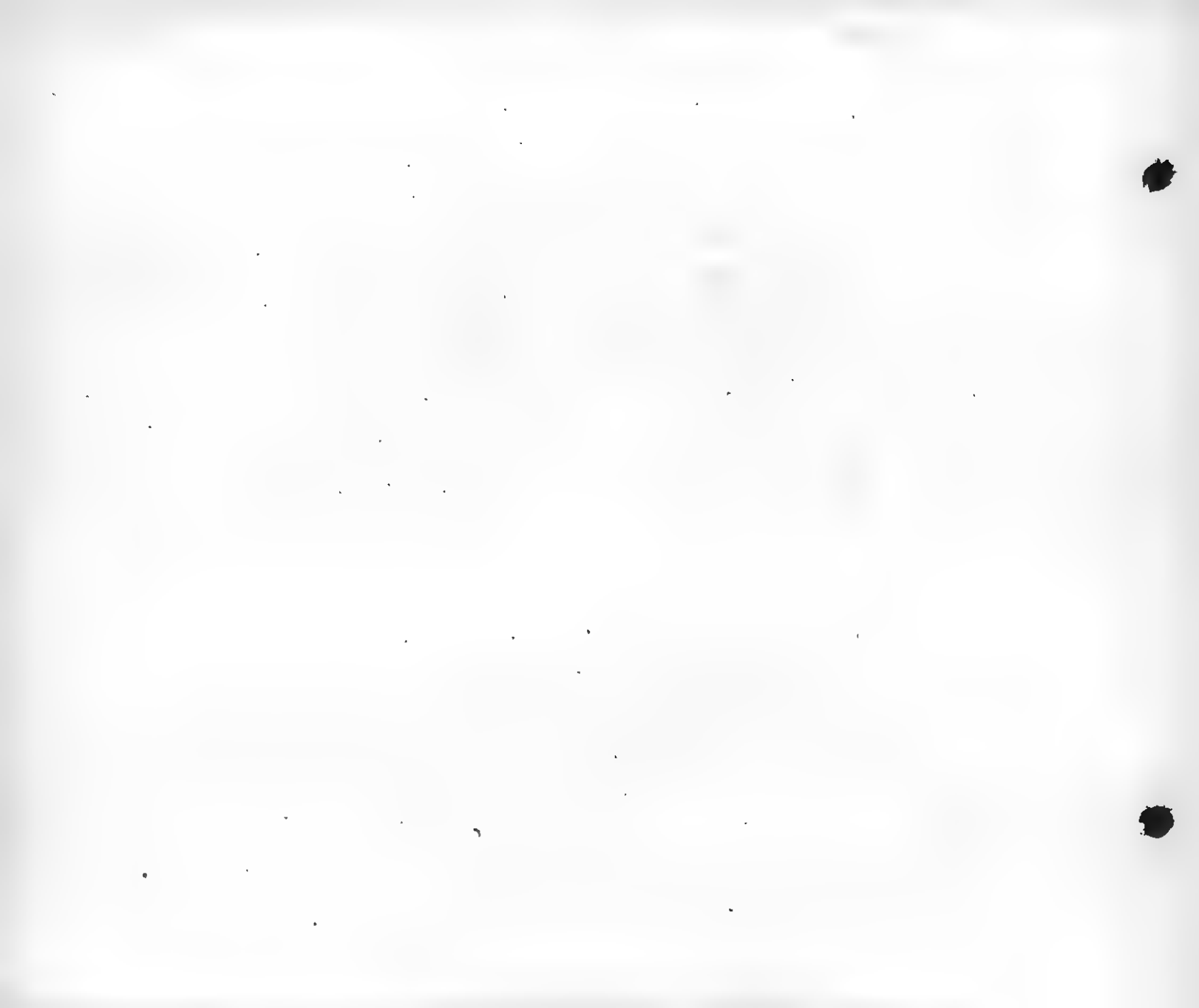
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Penna</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN b. <u>2 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>B</u> Last <u>Watson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 13, 1877</u>	
9. AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR Months <u>5</u> Days <u>13</u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumfresland Co, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Flavins B. Fuller</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Mains</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Shippensburg, Pa.</u> <u>Beattie Watson, 365 E. King St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Mononucleosis + Debility</u> <u>134.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General debility + Systemic infection</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <u>Not while</u> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Aug 1, 1958</u> to <u>June 29, 1959</u> that I last saw the deceased alive on <u>June 28, 1959</u> and that death occurred at <u>3:45</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>ME Byrkit</u> M.D.				ADDRESS (Street, city or town, state) <u>28 W Potomac</u>			
DATE SIGNED <u>6-29-59</u>							
PHYSICIAN'S NAME (Type) <u>ME Byrkit</u>				<u>Williamsport Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-1-1959</u>		<u>Spring Hill</u>		<u>Shippensburg Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin V. [unclear]</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 30 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur B. [unclear]</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7290

SALAMANDER STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07304

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 3 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 820 Washington Ave				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 820 Washington Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BESSIE ELIZABETH WIDMYER				4. DATE OF DEATH Month Day Year June 10 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10 1889	
9. AGE (In years last birthday) yrs. 70		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Md. Downsville Wash. Co	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Levi Cline			
14. MOTHER'S MAIDEN NAME Mattha Detrow				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 215-14-2153				17. INFORMANT Miss Mary Ditlow 820 Washington Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO General Arterio Sclerosis (c) 5 yrs				INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	
20f. (City or town) Hagerstown				20g. (County) Washington		20h. (State) Md.	
21. I certify that I attended the deceased from June 10, 1959 to June 10, 1959 , that I last saw the deceased alive on June 10, 1959 , and that death occurred at 10:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. M. Beachley				DATE SIGNED 6/12/59			
PHYSICIAN'S NAME (Type) J. M. Beachley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/59		22c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR JUN 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

200

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10-15-1880</u></p>	
<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>10-25-1950</u></p>	
<p>6. Place of death: <u>NEW YORK</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>	
<p>8. Signature of physician: <u>[Signature]</u></p>	
<p>9. Signature of registrar: <u>[Signature]</u></p>	
<p>10. Date of registration: <u>10-26-1950</u></p>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

7291

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 9 Film 6244 6-22-59 et
CERTIFICATE OF DEATH

07305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 20 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bessie Middle I Last Worthington				4. DATE OF DEATH Month 6 Day 15 Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-18-1885	
9. AGE (In years lost birthday) 63/64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Carroll Co. Ill.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Andrew C. Morgan				14. MOTHER'S MAIDEN NAME Martha A. Rohrer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mrs. John Perrott				Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerotic Heart Disease with 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ventricular Fibrillation DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity & Arteriosclerosis; Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-28- 1959 , to 6-15 1959 , that I last saw the deceased alive on 6-15 1959 , and that death occurred at 9:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 998 Potomac Ave Hagerstown, Maryland DATE SIGNED							
ACTUAL SIGNATURE DALTON M. WELTY M.D.				PHYSICIAN'S NAME (Type) DALTON M WELTY			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-18-59		22c. NAME OF CEMETERY OR CREMATORY Rest Haven		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 18 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraiss			

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General Instructions to the
Students of the

University of

1. The first thing you should do is to read the instructions carefully.
2. You should also read the instructions carefully.
3. You should also read the instructions carefully.
4. You should also read the instructions carefully.
5. You should also read the instructions carefully.
6. You should also read the instructions carefully.
7. You should also read the instructions carefully.
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